



Date

Wax Questionnaire

Please fill out all of the information as accurately and thoroughly as possible.

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: () _____ - _____ Best way to remind you of your appointment: CALL TEXT EMAIL

Email: _____ How did you hear about us? (Ad, Internet, Referred By) _____

Which body part are we waxing today? _____ Design? _____

When did you last shave or trim? _____ Have you been waxed before? Yes No When? _____

To you have any tendencies toward:

Are you currently using or taking:

| <i>Check Yes or No</i> | Yes | No |
|------------------------|-----|----|
| Ingrown hair | | |
| Breakouts | | |
| Bumps | | |
| Hyperpigmentation | | |
| Bruising | | |
| Scarring | | |
| Eczema | | |
| Psoriasis | | |

| <i>Check Yes or No</i> | Yes | No |
|------------------------|-----|----|
| Isotretinoin/Accutane | | |
| Retin-A | | |
| Alpha-hydroxy Acid | | |
| Any Scrubs or Peels | | |
| Indoor Tanning | | |
| Self Tanners | | |

Medical Data: Herpes Virus Yes No Staph / MRSA Yes No Allergies Yes No

List: _____

Other information: _____

Please read and initial next to the following:

_____ **Waxing may cause: Bruises, scabs, scarring, redness, hyperpigmentation, pimples or a flare up of any of the above-mentioned conditions/responses. Waxing of soft tissue may cause the skin to tear resulting in the need for stitches. (Most common occurrence is in Brazilian Bikini waxes, male or female.)**

_____ **I understand that if I have Herpes or Staph/MRSA, I may experience an outbreak after the waxing service. The professional has explained the best way to minimize or prevent an outbreak when waxing regularly.**

_____ **I understand I may carry Herpes and/or Staph/MRSA without any physical symptoms or a medical diagnosis. I also understand that the waxing service does not allow the opportunity to contract these conditions from my technician.**

_____ **I understand all of the above-mentioned reactions. I also understand if I change my skin care routine or medications, I must inform the professional PRIOR to any service in the future.**

_____ **I understand that I must be showered and prepared for my service.**

_____ **I understand that if I cancel or miss my appointment within the 24-hour cancellation policy I will be charged \$25.00 or HALF of the service fee, whichever is greater.**

Print Name

Client Signature

Date

Esthetician Signature

Date

FOR PROFESSIONAL USE ONLY:

Client Name: _____ **Date of Birth:** _____

Date: ___/___/___ Any changes? YES / NO Initial: _____ List: _____

Service Recap: Service: _____ Price: \$ _____ Products: _____

Date: ___/___/___ Any changes? YES / NO Initial: _____ List: _____

Service Recap: Service: _____ Price: \$ _____ Products: _____

Date: ___/___/___ Any changes? YES / NO Initial: _____ List: _____

Service Recap: Service: _____ Price: \$ _____ Products: _____

Date: ___/___/___ Any changes? YES / NO Initial: _____ List: _____

Service Recap: Service: _____ Price: \$ _____ Products: _____

Date: ___/___/___ Any changes? YES / NO Initial: _____ List: _____

Service Recap: Service: _____ Price: \$ _____ Products: _____

Date: ___/___/___ Any changes? YES / NO Initial: _____ List: _____

Service Recap: Service: _____ Price: \$ _____ Products: _____

Date: ___/___/___ Any changes? YES / NO Initial: _____ List: _____

Service Recap: Service: _____ Price: \$ _____ Products: _____

Date: ___/___/___ Any changes? YES / NO Initial: _____ List: _____

Service Recap: Service: _____ Price: \$ _____ Products: _____

Date: ___/___/___ Any changes? YES / NO Initial: _____ List: _____

Service Recap: Service: _____ Price: \$ _____ Products: _____

Date: ___/___/___ Any changes? YES / NO Initial: _____ List: _____

Service Recap: Service: _____ Price: \$ _____ Products: _____