WAX QUESTIONNAIRE

Today's Date _____

Name_____

Birthday _____/_____/_____

Address_____ City_____ State_____ Zip_____

Phone (_____) _____--_____

Best way to remind you of your appt: CALL / TEXT / EMAIL

Email _____

How did you hear about us? AD / INT / REF NAME: _____

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

When did you last shave or trim? _____ Have you been waxed before? YES / NO When? _____

Do you have any tendencies towards:

Ingrown hair YES / NO	Hyperpigmentation YES / NO	Eczema YES / NO
Breakouts YES / NO	Bruising YES / NO	Psoriasis YES / NO
Bumps YES / NO	Scarring YES / NO	

Are you currently using or taking:

Isotretinoin/Accutane YES / NO	Resorcinol YES / NO	Indoor Tanning YES / NO
Retin-A YES / NO	Glycolic Acid YES / NO	Self Tanners YES / NO
Alpha-hydroxy Acid YES / NO	Any Scrubs or Peels YES / NO	

Medical Data:

Herpes Virus YES / NO	Staph/MRSA YES / NO
Allergies YES / NO	

If yes please list: _____

Other information: _____

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   Print Name

_____   _____
Authorizing Signature Date   Technician Signature Date

For Professional Use:

Date: ____ / ____ / ____   Changes? YES / NO   List: _____   Initial: _____

Service: _____   Price: $ _____   Products: _____

Next Appointment: _____   Notes: _____

Date: ____ / ____ / ____   Changes? YES / NO   List: _____   Initial: _____

Service: _____   Price: $ _____   Products: _____

Next Appointment: _____   Notes: _____

Date: ____ / ____ / ____   Changes? YES / NO   List: _____   Initial: _____

Service: _____   Price: $ _____   Products: _____

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Date: ____ / ____ / ____   Changes? YES / NO   List: _____   Initial: _____

Service: _____   Price: $ _____   Products: _____

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Date: ____ / ____ / ____   Changes? YES / NO   List: _____   Initial: _____

Service: _____   Price: $ _____   Products: _____

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Date: ____ / ____ / ____   Changes? YES / NO   List: _____   Initial: _____

Service: _____   Price: $ _____   Products: _____

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Date: ____ / ____ / ____   Changes? YES / NO   List: _____   Initial: _____

Service: _____   Price: $ _____   Products: _____

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Date: ____ / ____ / ____   Changes? YES / NO   List: _____   Initial: _____

Service: _____   Price: $ _____   Products: _____

Next Appointment: _____   Notes: _____

Date: ____ / ____ / ____   Changes? YES / NO   List: _____   Initial: _____

Service: _____   Price: $ _____   Products: _____

Next Appointment: _____   Notes: _____