HAIR REMOVAL INTAKE FORM

Name:_____ Date of Birth:_____ Email Address:_____

What area(s) of the body are being treated today?_____

Is this your first time receiving this service? _____

Do you have any precancerous lesions or have ever been treated for cancer?

_____

Are you diabetic? _____

Are you currently taking any medications? _____

If so please list_____

Do you sun bathe or use a tanning bed? _____

If so, when was your last exposure? _____

Do you have, or are prone to: (please circle all that apply)

Ingrown hairs Varicose veins

Scarring Bruising

Allergies If so please list:_____

I have read the above information and if I had any concerns, I have addressed them with my esthetician. I give
permission to my therapist to perform the waxing procedure we have discussed and will hold her harmless from
any liability that may result from this treatment. I have given an accurate account of the questions asked
above including all known allergies or prescription drugs or products I am currently ingesting or using topically. I
understand my esthetician will take every precaution to minimize or eliminate negative reactions.

I have read and understand the post-treatment home care instructions. I am willing to follow the
recommendations made by my esthetician for a home care regimen that can minimize or eliminate possible
negative reactions. In the event that I may have additional questions or concerns regarding my treatment or
suggested home product/post-treatment care, I will consult my esthetician immediately.
I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I
certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity
for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold
the esthetician, whose signature appears below, responsible for any of my conditions that were present, but
not disclosed at the time of this skin care procedure, which may be affected by the treatment performed
today.

Client Name (printed) _____

Date _____

Client Name (signature) _____ Date _____

Aesthetician Signature _____

Date _____