

Waxing Release Form

Client: _____ Date: _____

Address: _____

Birthday: _____ Email: _____

How did you hear about us? _____

Have you been waxed before? Y / N What areas? _____

Any problems? _____

Do you take any of the following or use products that contain the following: (please circle)

Accutane (Note: you must be off this medication treatment course for a minimum of one (1) year prior to waxing surfaces)

Tetracycline Retin-A Renova Glycolic, Lactic or Salicylic Acid Hydroquinone Topical Cortisone

If so, how long ago?

Are you currently using any products or medications for acne or aging? If so, please list: (note: any anti-aging or acne medication including pro-active must be stopped seven (7) days prior to waxing surfaces)

Have you had any of the following procedures? (Please circle)

Chemical Peel Laser Resurfacing Removal of Skin Cancer Microdermabrasion Any Other Major Exfoliation Procedures

If so, how long ago and what areas?

Do you currently have any of the following? (Check all that apply)

___ Diabetes ___ Dermal Abrasions ___ Warts ___ High Blood Pressure

___ Poor Circulation ___ Edema ___ Recent Scar Tissue ___ Varicose veins/Phlebitis

___ Sunburn ___ Pregnancy ___ Epilepsy ___ Undiagnosed Lumps/Bumps

