handcrafted therapy

WAXING INTAKE FORM

Name: _____ Date of birth: _____

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

Phone Number: _____ Occupation: _____

Email: _____ Referred by: _____

Emergency contact name: _____ Emergency contact phone: _____

Physician's contact name: _____ Physician's contact phone: _____

Body part being waxed: _____ Last time you shaved: _____

Frequency you shave: _____

Do you have tendencies to any of the following:

Ingrown hairs	yes ___ no ___	Hyperpigmentation	yes ___ no ___
Scarring	yes ___ no ___	Bruising	yes ___ no ___
Bumps	yes ___ no ___	Allergies	yes ___ no ___

If yes, what? _____

Are you currently using or taking any of the following:

Accutane	yes ___ no___	Resorcinol	yes ___ no___
Retin-A	yes ___ no ___	Glycoloic Acid	yes ___ no ___
Alpha-hydroxy Acid	yes ___ no ___	Scrub or Peel of any kind	yes ___ no ___

Any other medications: _____

I confirm that the information that I have provided is accurate and complete to the best of my knowledge. I have not withheld any information that may be relevant to my treatment and/or the results thereof. I am aware that there is often inherent risks associated with skin care services including waxing procedures, and the services I am about to receive may cause bruises, scabs, scarring, redness, hyperpigmentation or pimples and these are all normal reactions. I also understand that use of any of the above products increases possibility of a reaction, so if I start to use them I must inform my service provider.

By signing below, I agree that I will not hold Handcrafted Therapy or its employees responsible should there be any unfavorable outcome or result.

Signature: _____ Date: _____

Signature of parent/guardian if client is a minor: _____ Date: _____