# Client Consent/Consult – Waxing

Name:_____ Date _____

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

Phone: _____ Date of Birth:_____ Occupation:_____

Email Address: _____ How did you hear of us?_____

Would you like to receive my monthly newsletter/Hear about specials and events? ☐ No ☐ Yes

Emergency contact:_____ Phone:_____ Relationship to you:_____

Have you used Alpha Hydroxy Acid (AHA)/glycolic products in the past 48-72 hrs? ☐ No ☐ Yes

Are you using Retin-a, Renova or Accutane (an oral form of Retin-a)? ☐ No ☐ Yes

Are you using any other skin thinning products and/or drugs? ☐ No ☐ Yes

Are you exposed to sun on a daily basis or will be spending time in the sun soon? ☐ No ☐ Yes

Do you use a tanning bed? ☐ No ☐ Yes Are you diabetic? ☐ No ☐ Yes

Are you currently taking medications? If so, please list all (including over the counter drugs/herbal supplements): _____

_____

What skin products do you regularly use on your skin? _____

_____

Have you ever been treated for cancer? If yes, when and what types of therapies were used? _____

_____

Please list any other illness/condition you are currently being treated for by a medical professional_____

_____

***(Female clients)*** (Always allow five days for menstrual cycle. Because of water retention and for your own personal comfort, you should avoid hair removal two days before your cycle is due and two days after it is completed.)

***Please note that waxing does have certain side effects such as skin removal, redness, swelling, tenderness, etc.***

_____ I have not used a scrub, Retin-A, Retinol OTC, take home micro-dermabrasion, glycolic peels, other peels, exfoliated or tanned in the last 72 hours.

_____ I have been off of Accutane for at least twelve (12) months.

_____ Some possible side effects include redness, swelling and pimples, but these are temporary and generally fade within 72 hours.

_____ For Brazilian and/or bikini waxing, I will notify my service provider if I am on my menstrual cycle. _____ I do not have any open skin lesions or active herpes outbreak (cold sore or genital).

_____ I understand that with treatment certain risks are involved and that any complications or side effects from known or unknown causes could occur. I freely assume these risks.

_____ I agree to adhere to all safety post care including: no peels, tanning or wet room services; no swimming/spas/hot tubs for 72 hours after waxing; and all home skin care protocols as recommended by my service provider.

_____ I am over 18 years of age or I have parental consent co-signed below.

_____ I will call to inform my service provider of any complications or concerns I may have as soon as they occur.

_____ I consent to “before and after” photographs for the purpose of monitoring treatment effects, documentation, potential advertising and promotional purposes.

***OVER***

I understand that any information provided is to aid the service professional in giving better service and is completely confidential. I understand, have read and completed this questionnaire honestly and truthfully. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I agree to keep the service provider updated to any changes in my medical profile and understand that there should be no liability on the service providers part should I fail to do so. I give permission to my skin care specialist to perform treatment we have discussed, and will hold him/her and his/her staff harmless and nameless from any liability that may result from this treatment. I understand my skin care specialist will take every precaution to minimize or eliminate negative reactions as much as possible. If I experience any discomfort or pain during the session, I will immediately inform the service professional. In the event I may have additional questions or concerns regarding my treatment, I will consult the skin care specialist immediately. I understand that the services offered are not a substitute for medical care. I also understand that the service provided, and advice of the provider should not be construed as a substitute for a medical examination, diagnosis, or treatment and that I should see a medical professional for any mental or physical ailment I am aware of. I understand the service professional is not qualified to diagnose, prescribe, or treat any skin disease or disorder and nothing said during the course of the appointment be construed as such. 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 skin care specialist responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today. By signing below, I hereby authorize Bliss by Sherise to administer treatment services to me, and will hold Bliss by Sherise or its service providers harmless from any liability that may result from this treatment. I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature _____ Date_____

SUBMIT

***OVER***