BEAUTIFUL PEOPLE SALON & DAYSPA

WAXING INTAKE FORM

_____

DATE

Name _____ **Age** _____

Address _____ **Email** _____

Phone _____ **Specialist** _____

Do any of the following apply to you?

- Diabetes
- Epilepsy
- Oedema
- Phlebitis
- Hypersensitive skin
- Varicose Veins
- Psoriasis
- Poor circulation
- Sunburn
- Moles
- Skin Disease
- Pregnancy
- Prescribed medicine
- New scar tissue
- Others, please specify _____

Do you use any of these products?

- Retin A
- Glycolic acid
- Accutane
- Oedema

Have you had waxing before? **YES** **NO**

Do you have any known allergies? **YES** **NO**

If yes, please indicate _____

By signing below you have agreed to the following,

I have completed this form to the best of my ability and knowledge and agree to inform the technician of any changes in the above information. I have been informed and understand the contradictions to the requested treatments and agree that I do not have any condition(s) that would make the requested treatmemt unsuitable.

Signature _____