WAXING SERVICES
Client Profile
Images by B

Name:_____
First mi last

Complete Mailing Address:_____

City:_____State_____Zip_____

Phone: ( )_____ email:_____@_____

Work: ( )_____ Birthday:_____(month)_____(day)

Alt Phone:_____

How did you hear about our salon?

_____Referral _____Location/Sign _____Newspaper Ad _____Yellow Pages _____Web Page
Other:_____

We would like to thank the person who referred you to our salon, could we please have their name?

Would you like to be put on our email list for special offers and/or newsletter for our clients? _____yes _____no
Your email address will not be given out or sold.

I have a history of:

____Diabetes ____Dermal Abrasions ____Stomach Ulcers

____High Blood Pressure ____Excessive Moles ____Poor Circulation

____Warts ____Vericose Veins ____Any other:_____

I take the following medications:

____Acutane ____Tetracyline ____Stomach Ulcers

____Thyroid Medication ____Retin-A (in the last y months) ____High Blood Pressure Medication

____Any other medications:_____

____*I am under the care of a dermatologist*?

*I tanned in the natural sunlight on:*_____

*I tanned in a tanning bed/booth on:*_____

*I had a chemical peel on :*_____

*I had waxing done on:*_____

***DO NOT EXPOSE SKIN TO THE SUN/INDOOR TANNING FOR AT LEAST 48 HOURS AFTER WAXING SERVICES.*
I UNDERSTAND THAT I AM ACCEPTING ANY REACTION FOR A WAXING SERVICE.

Client Signature:_____Date:_____