The Garden Day Spa & Salon

 CONFIDENTIAL WAXING CONSULTATION

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_/\_\_\_\_\_\_/ 20\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (circle) MALE / FEMALE

MOBILE PHONE(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_REFERRED BY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WAXING and GENERAL HEALTH QUESTIONNAIRE

**Do you have any tendencies towards the following?**

**Ingrown Hair** □ No □ Yes

**Break Outs** □ No □ Yes

**Bumps** □ No □ Yes

**Hyperpigmentation** □ No □ Yes

**Bruising** □ No □ Yes

**Scarring** □ No □ Yes

**Eczema** □ No □ Yes

**Psoriasis** □ No □ Yes

**Do you suffer from any allergies?**

(cosmetic ingredients, food, iodine, medications, hay fever, latex)

□ No □ Yes (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently undergoing chemotherapy or radiation therapy?**

□ No □ Yes (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently taking any medications including antibiotics or completed any, herbs, vitamins?**

□ **Internal/Oral**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ **Topical**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you taken any oral steroids like prednisone in the past 1-2 months?**

□ No □ Yes (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you taken blood thinners in the past 6 months?**

□ No □ Yes (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever been prescribed Accutane or any skin-thinning or exfoliating drugs, including Retin-A, Renova, Tazorac, Differin, Glycolic or Alpha Hydroxy Acids(AHAs)?**

□ No □ Yes (please specify drug and last date used)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand, have read and completed this questionnaire truthfully. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof. I understand that the services offered are not a substitute for medical care and any information provided by the esthetician is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the esthetician in giving better service and is completely confidential.**

 **SPA Policies: Visit thegardenspa.net to read the full policies.**

1. **Professional consultation is required before initial dispensing of products.**
2. **We require a 24-hour cancellation notice.**

**I fully understand and agree to the above spa policies.**

 **Client’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_/\_\_\_\_\_\_/20\_\_\_\_\_\_**

 **Esthetician’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_/\_\_\_\_\_\_/20\_\_\_\_\_\_**

**Do you have any of the following:**

**Herpes Virus** □ No □ Yes

**Staph / MRSA** □ No □ Yes

**How often do you consume alcohol?**

□ Regularly □ Seldom □ Never

**How many glasses of water do you consume daily?**

□ 1-2 □ 3-5 □ 6-8+