Client Intake Form

Client Information

Date_____

If previously filled out this form: Any changes since last visit? No _____ Yes: please indicate changes on form
Initial

Name:_____ Gender: M F Age:_____ Date of Birth:_____

Address:_____ City:_____State:_____Zip_____

Preferred contact number:_____ Email:_____

May we leave a message if we do not reach you personally? Yes No

What are your top 3 concerns at this time?

1._____ 2._____ 3._____

Medical History:

Pregnant? Yes No Maybe N/A Breastfeeding? Yes No N/A Do you Smoke? Yes No

Health conditions:_____

Past Surgeries:_____

Have you ever been diagnosed with Cancer? No Yes: Date of last treatment:_____

Current Medications:_____

Prescription Topicals:_____

Allergies (include aspririn/iodine):_____

Previous Treatments:

Facials:	Yes No	Last treatment:_____	Any complications?_____
Microdermabrasion:	Yes No	Last treatment:_____	Any complications?_____
Chemical Peels:	Yes No	Last treatment:_____	Any complications?_____
Waxing:	Yes No	Last treatment:_____	Any complications?_____
Tanning:	Yes No	Last treatment:_____	Any complications?_____
Laser Therapy:	Yes No	Last treatment:_____	Any Complications?_____
Massage:	Yes No	Last treatment:_____	Preferred Pressure: Light Medium Deep

Skin Conditions: (please circle the items below that pertain to you)

Skin Infection	Herpes (cold sores)	Keloids/Excessive Scarring	Sun Sensitivity
Skin Cancer	Poor Healing	Tattoos/Permanent Makeup	Easy Bruising
Eczema	Psoriasis	Lymph Nodes Removed	Diabetes

Other:_____

Skincare: What type of skin do you feel you have? Dry Oily Normal Combination Sensitive
What is your skin routine? (Indicate any cleansers, toners, serums, moisturizers, masks, sunscreens, etc.)

1._____ 4._____

2._____ 5._____

3._____ 6._____

Waxing Consent Form

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____
Email Address: _____
Referred By: _____

I, _____ give consent to Pamela Sander to perform the following wax services: _____

- I have not used a scrub, Retin-A, Retinol OTC, take home micro-dermabrasion, glycolic peels, other peels, exfoliated or tanned in the last 4 weeks _____ (Initial)
- I have been off Accutane for at least 12 months. _____ (Initial)
- Some possible side effects include redness, swelling, and pimples, but are temporary and generally fade within 72 hours. _____ (Initial)
- (For Brazilian waxing only) I am not in my menstrual cycle. _____ (Initial)
- I do not have any open skin lesions, active herpes outbreak (cold or genital). _____ (Initial)
- I understand that with treatment certain risks are involved and that any complications or side effects from known or un-known causes could occur. I freely assume these risks. _____ (Initial)
- I agree to adhere to all safety post care including: no peels, tanning, or wet room services for 72 hours to one week and all home skin care protocols as recommended _____ (Initial)
- I am over 18 years of age or I have a parental consent co-signed below. _____ (Initial)
- I will call to inform Pamela Sander of any complications or concerns I may have as soon as they occur. _____ (Initial)

My signature acknowledges that I have read and agree to receive the following treatments or series of treatments listed above and that I adhere to all the above statements I have initialed.

Client Signature: _____ **Date:** _____

Witness or Parent Signature: _____ **Date:** _____

We have the right to refuse services for all waxing if proper hygiene has not been followed. Please cleanse before Brazilian and Bikini waxes. Thank you.

Waxing Case History

Date_____

Name_____
Last First Middle
Address_____
Street
_____
City State Zip Code
Phone-Home (___) _____Work (___) _____ext.____

Referred By:_____
- ☐ Friend or Relative
- ☐ Newspaper
- ☐ Yellow Pages
- ☐ Other_____

AREAS REQUESTED TO BE TREATED:

_____
_____
_____

TEMPORARY REMOVAL ATTEMPTS:
- ☐ Depilatory
- ☐ Shave
- ☐ Tweeze/Pluck
- ☐ Wax
- ☐ Other

_____
_____

Medical & Cosmetic History

	Yes	No	Comments
1. Acne			
2. Allergies			
3. Bleeder/Hemophiliac			
4. Cold Sores			
5. Diabetes			
6. Heart Condition			
8. Hepatitis "B"			
9. Exfoliation Products used:			
a. Alpha Hydroxy Acids			
b. Retin A			
c. Accutane			
d. Renova			
e. Other_____			
10. Medications: list			
a. Baby Regular Aspirin			
b. Blood Thinners			

For Office Use Only

Any skin lesions:

_____ _____
_____
_____
_____

Other Possible notes:

_____
_____
_____
_____
_____
_____
_____
_____

Questionnaire:

1. Have you ever had a bad waxing experience? If yes, please explain:

   _____
   _____
   _____
2. Do you experience in-grown hairs when waxing?

   _____
3. Do you break-out after waxing?

   _____
4. Would you say you have sensitive skin?

   _____

Waxing:

1. Possible side affects?
   - ➢ Possible irritated skin up to 1-2 days
   - ➢ Scabbing
   - ➢ Pustules
2. What if I feel hairs in a few days?
   These are new hairs that were growing but had not reached the surface at the time of the waxing.
3. Sometimes after waxing I still feel a few hairs. Why?
   These are hairs that are to short for the wax to adhere to at the time of the waxing. They need to grow first.
4. Will the wax get on my clothes?
   In the bikini line area it is possible for some wax to adhere to your bathing suit or underwear so you should wear an old pair or WE have disposable underwear you may purchase.

After Care:

Cleanse, apply an antibacterial ointment to protect area. Cool cloths applied to reduce irritation.

Sign_____ Date_____

HAIR REMOVAL CLIENT PROFILE

ame: _____ DOB: _____ Age: _____ Sex: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-Mail Address: _____

How did you hear abc ut us?

Web page___ Client _____ Ye llow Pages ___
Friend __Walk-In ___
Other _____
Name:_____

1) Area(s) to be treated: _____
2) Are you pregnant? Yes____ No ___ 3) Are you in or past menopause? Yes ____ No ____
4) Do other family members have exc essive hair? Yes ____ No ____ Relationship _____
5) Check all previous/current methods of hair removal: Shaving ___ Clipping ___ Tweezing ____
Waxing ____ Electronic Tweezers ____ Depilatories (NARE, etc.) ____
List the last time you did any of the checked items: _____
6) List previous laser/electrolysis treat nents: First treat. date: _____ Last treat. date _____
Electrolysis modality: Thermolysis _____ Blend _____ Galvanic (multi-needle) _____
Laser Type _____
7) Do you have any permanent make-up or tattoos? Yes ____ No ____ Explain: _____
8) Have you recently been in the sun, been wind-burned, or been to a tanning booth? Yes ____ No ____
If yes, when was your last exposure? _____
9) Are you currently using Retin-A/Re ova/Differin/Efudex/Psoralen/Bleaching Agents? _____ No _____
If yes, where was it applied? _____
10) Are you currently using or have you ever used Accutane, Accitretan, Psoretaine? Yes _____ No _____
If yes, explain: _____
11) Have you ever had microdermabra ion or chemical peel? Yes ____ No ____ If yes, how long ago? _____
Explain: _____
12) Have you recently had facial surge y or laser resurfacing? Yes ____ No ____ If yes, how long ago? ____
Explain: _____
13) Do you smoke? Yes ____ No ____ If yes, how much per day? _____
14) Do you get cold sores/fever blisters? Yes ____ No ____ If yes, last breakout? _____
15) Are you sensitive to alcohol-based products? Yes ____ No ____
16) List any items you are allergic/sens tive to: _____
17) Are you taking any mood altering o depression medications at this time? Yes ____ No ____
If yes, please list: _____
18) Are you taking any other medicatio s at this time? (antibiotics increase sensitivity) Yes ____ No ____
If yes, please list: _____
_____
19) Describe your skin (check all that a ply): Acne ____ Comedones ____ Breakouts ____ Freckled ____
Small Pores ____ Rosacea ____ E zema ____ Uneven/blotchy ____ Melasma ____ Perfume-stained ____
Sun-damaged ____ Psoriasis ____ Hypo-pigmentation ____ Hyper-pigmentation ____
Telangiectasia (surface capillaries) ____ Asphyxiated ____ Explain any of the above: _____
20) Have you had any of the following within the last year (check all that apply)? Bruising ____ Age Spots ____
Pigment Changes ____ Eczema ____ Warts ____ Dermatitis ____ Keloids ____ Scars ____
21) Have you ever had or been treated for the following (check all that apply)? Diabetes ____
Hemophilia ____ Bleeding Problem s ____ Cancer ____ High Blood Pressure ____
Sexually Transmitted Diseases ____ Herpes ____ pacemaker ____ Hodgkin's disease ____
Hepatitis ____ (Type ____) HIV Blo od Test ____