Refine Aesthetics

CLIENT INFORMATION/MEDICAL HISTORY

Name _____Age_____ Date_____

Address_____City_____State_____Zip_____

Email Address_____

Cell_____ Date of Birth_____

Emergency Contact_____Relationship_____Cell_____

Medications (Prescriptions/over the counter med, vitamins, herbal medications)

_____

_____

Drug Allergies_____

Major Surgeries/Facial surgeries_____

Ongoing facial treatments? (Injectibles/Laser/chemical peels/waxing/facials)_____

Please circle if you have any of the following conditions –

Heart Disease Excessive Bleeding High Blood Pressure Hepatitis Skin Cancer Liver Disease

Lupus Auto-Immune Disorders Diabetes Neuromuscular Disease Cold Sores/Fever Blisters

Lidocaine allergy/sensitivity

Pregnant? Y N Breastfeeding? Y N

The above information is true and accurate to the best of my knowledge.

_____

_____ _____

Client Signature **Date**

WAXING

CONSENT FORM

I _____ give my consent to receive waxing treatments.

Are you affected by or have any of the following?

- ☐ Pregnant/Lactating
- ☐ Tanning by Booth or Sun
- ☐ HIV/AIDS
- ☐ Diabetes
- ☐ Rosacea
- ☐ Skin Cancer
- ☐ Cold Sores/Herpes
- ☐ Hepatitis
- ☐ Recent Chemical Peels
- ☐ Eczema/Psoriasis
- ☐ Immune Disorders
- ☐ Varicose Viens
- ☐ Excessive Telangiectasias
- ☐ Hemophilia/Blood Thinners

Other Medical Conditions _____

Current Medications _____

By signing below, you agree to the following:

I understand that results will vary between individuals and no guarantees have been made regarding my personal results. I understand that my results may be compromised if I do not follow the aftercare instructions that I have been given.

I understand that if I am using or begin to use any products or medications listed on this page it is my responsibility to inform the technician prior to this treatment and all future treatments.

I have been informed of and understand the contraindications to the requested treatments and agree that I do not have any condition(s) and I am not using any products that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly.

The procedure and side effects have been explained to me and I have had the opportunity to ask questions. My questions have been answered in a satisfactory manner.

I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred. I accept all risk and liability for this cosmetic procedure. This consent form is valid for future treatments until it is rescinded by me in writing.

_____

Client Signature (Guardian if under 18)

Date _____

[wăks-ing] verb

the process of hair removal from the root by using a substance to adhere to body hair, and then removing this substance which pulls the hair out from the follicle.

In the last 14 days, I have NOT used any of the following:

Retin A	Azelaic Acid
Altinic	Tazarotene
Renova	Retinol
Avage	Differin
Tretinoin	Retin-A

Vitamin A Derivitive Products

initial_____

I have NOT used Alpha-Hydroxy Acid, Glycolic Acid, Salycylic Acid, Hydroquinone, or over the counter steroid creams in the last 48 hours.

initial_____

I have NOT taken Accutane in the past 12 months.

initial_____

I have NOT used Prednisone, topical or oral steroids, topical or oral antibiotics in the last 14 days.

initial_____

I understand that the following are potential side effects:

Redness	Bumps
Irritation	Bruising
Breakouts	Skin Lifting
Ingrown Hairs	Sun Sensitivity
Infection	Bleeding