Helen WAX Spa

Naturally Organic Spas
All Locations
Client Health Questionnaire

Name_____

Home Phone _____ Cell Phone _____ Email_____

Address _____ City_____ State ____ Zip _____

Date of Birth __ / __ / ____

Referred by: _____

**Medical Information:** check all that apply

| | | | |
|---|---|---|---|
| ☐ Pregnant | ☐ Birth Control | ☐ Hormone Replacement | ☐ Smoker |
| ☐ Oral Antibiotic | ☐ Topical Antibiotic | ☐ Steroids | ☐ Asthma |
| ☐ Neck / Back Pain | ☐ Headaches | ☐ Migraines | ☐ Seasonal Allergies |
| ☐ Latex Allergy | ☐ Peanut Allergy | ☐ Iodine Allergy | ☐ Aspirin Allergy |
| ☐ Hypertension* | ☐ Heart Disease* | ☐ Pacemaker* | ☐ Foreign Objects |
| ☐ Diabetic | ☐ Prone to Cold Sores | ☐ Epilepsy | ☐ Herpes |
| ☐ Rashes/Hives | ☐ Shingles | ☐ Bursitis | ☐ Skin Cancer |
| ☐ Rosacea | ☐ Use Retinol | ☐ Use Tazorac | ☐ Use Accutane |

☐ Currently under Physician's Care _____

**Daily Home Regimen:** check all that apply:

| | | | |
|---|---|---|---|
| ☐ Facial soap | ☐ Facial Cleanser | ☐ Toner | ☐Moisturizer |
| ☐ Masque | ☐ Exfoliator / Scrubs | ☐ Eye Product | Brands: _____ |
| ☐ Sunscreen Daily | ☐ Sunscreen Recreationally | | ☐ Tan/Tanning Beds |

**Are you currently using any products that contain the following ingredients?**

☐ Glycolic Acid ☐ Lactic Acid ☐ Hydroxy Acid ☐ Vitamin A Derivatives

**Skin Concerns:** check all that apply

| | | | |
|---|---|---|---|
| ☐ Premature Aging | ☐ Sun Damage | ☐ Wrinkles | ☐ Texture/Tone |
| ☐ Pigmentation | ☐ Acne | ☐ Flushing/Redness | ☐ Pore Size |

**When going out in the sun do you:**

| | | | |
|---|---|---|---|
| ☐ Sometimes Burn (III) | ☐ Rarely Burn (IV) | ☐ Very Rarely Burn (I) | ☐ Never Burn (VI) |
| ☐ Always Burn (I) | ☐ Usually Burn (II) | | |

I understand that the use of certain medications and over the counter products can significantly increase the risk of adverse reactions and/or injury. I hereby confirm that I am not using any medication that may cause or contribute to any such reaction/injury and I will advise my esthetician should I begin using any such medication in the future. I understand that there are inherent risks associated with skincare services, and I agree that as a condition of providing these services on an ongoing basis, I will not hold responsible anyone at Helen Wax Spa, **Inc.** should there be any unfavorable outcome or result.

Client Printed Name: _____

Client Signature: _____ Date: _____

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Waxing Questionnaire & Consent Form

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell: _____ E-mail: _____

How did you hear about Helen Wax Spa, Inc.? _____

What body area/areas or conditions would you like treated? _____

When did you last shave? _____ When is your menstrual cycles start date? _____

*Due to water retention and your personal comfort, avoid hair removal two days before your cycle starts and two days after.

| Do you have or are you prone to? | | | Have you used any of the following in the last 48-72 hours? | |
|---|---|---|---|---|
| Ingrown hairs | Yes No | | Accutane | Yes No |
| Scarring | Yes No | | Retin-A | Yes No |
| Bumps | Yes No | | Alpha-hydroxy Acid | Yes No |
| Hyperpigmentation | Yes No | | Glycolic Acid | Yes No |
| Bruising | Yes No | | Resorcinol | Yes No |
| Allergies | Yes No | | Scrub or Peel | Yes No |
| If yes, what to? _____ | | | Have you used other skin Thinning medications? If so, which? _____ | Yes No |
| Are you diabetic? | Yes No | | Do you use a tanning bed? | |
| Have you ever been treated for cancer? | Yes No | | How are you feeling today, on a scale from 1-10? | 1 2 3 4 5 6 7 8 9 10 |
| Any other illness/condition you are presently being treated for by a medical professional? | | | | |

**Please note that waxing does have certain side effects such as skin removal, redness, swelling, tenderness and other unforeseen side effects.**

I have read the above information and if I had any concerns, I have addressed them with my esthetician. I give permission to my therapist to perform the waxing procedure we have discussed and will hold her harmless from any liability that may result from this treatment. I have given an accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesting and using topically.
I have read and understand the post – treatment home care instructions. I am willing to follow the recommendations made by my esthetician for a home care regimen that can minimize or eliminate possible negative reactions. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult my esthetician immediately.
I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Printed Name: _____

Client Signature: _____ Date: _____