



## Waxing Profile & Release Form

All information given will be kept confidential and used only by service professionals.

Name (Last, First, M.I.) \_\_\_\_\_ Date \_\_\_\_\_

### Waxing/Health History

*Please check all that apply*

- \_\_\_\_\_ Have you had waxing done before? What areas? \_\_\_\_\_
- \_\_\_\_\_ Have you ever experienced any reaction or breakout? Please describe \_\_\_\_\_
- \_\_\_\_\_ Have you used any products in the area to be waxed? What kind? \_\_\_\_\_
- \_\_\_\_\_ Do you currently use sunscreen? What SPF? \_\_\_\_\_
- \_\_\_\_\_ Do you currently tan (indoor or outdoor)? Date last tanned \_\_\_\_\_
- \_\_\_\_\_ Do you develop cold sores/fever blisters? Date of last outbreak \_\_\_\_\_
- \_\_\_\_\_ Do you have varicose veins? \_\_\_\_\_
- \_\_\_\_\_ Is your menstrual period due within the next week? \_\_\_\_\_
- \_\_\_\_\_ Have you ever used Renova, Differin or Tazorac? Date of last use \_\_\_\_\_
- \_\_\_\_\_ Have you ever used Retin-A? Date of last use \_\_\_\_\_
- \_\_\_\_\_ Have you ever used any topical medications or AHAs? Date of last use \_\_\_\_\_
- \_\_\_\_\_ Have you ever used Accutane? Date of last use \_\_\_\_\_
- \_\_\_\_\_ Have you ever had microdermabrasion done? Date of last treatment \_\_\_\_\_
- \_\_\_\_\_ Have you ever had a chemical peel? Date of last treatment \_\_\_\_\_
- \_\_\_\_\_ Have you ever had any laser treatments? Date of last treatment \_\_\_\_\_
- \_\_\_\_\_ Are you taking any medications at this time? Please list/explain \_\_\_\_\_

### Known Allergies

*Please circle all that apply*

Soy Latex Other (please list) \_\_\_\_\_

I understand that I must avoid direct sunlight for at least 24 hours and wear at least an SPF 25 for 48 hours post-treatment. I further understand that some redness, irritation, ingrown hairs, and small white bumps may occur and that waxing may stimulate the activity of cold sores or fever blisters. I understand the procedure of waxing that will be performed today, and I will not hold Dolce Salon & Spa or its employees liable for any type of reaction that may occur.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Professional Signature \_\_\_\_\_ Date \_\_\_\_\_

## For Professional Use Only

Professional Name _____	Date _____
Waxing Service(s) _____	
Any changes to information listed on reverse (prescriptions, allergies, cold sores/fever blisters, etc.)? _____	
_____	
I attest that I have advised my professional of any changes to the information listed on reverse.	
Client Initials/Date _____	Professional Initials/Date _____
Professional Notes _____	
_____	

Professional Name _____	Date _____
Waxing Service(s) _____	
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