

Claudia's Body and Skin Care Center

CLIENT PROFILE - WAXING SERVICES

Name _____

Phone (H) _____ (W) _____ (C) _____

Address _____ City _____ State _____ Zip _____

Referred by: _____ Email _____

Physician _____ Are you under doctor's care? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Please indicate by marking and "X" whether you have now or have ever had any of the following medical conditions:

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dermal Abrasions | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Excessive Moles | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Warts | <input type="checkbox"/> Varicose Veins | |
| <input type="checkbox"/> Any other skin condition (please explain below) | | |
- _____
- _____

Please indicate by making and "X" whether you are taking any of the following medications:

- | | | |
|---|---|---|
| <input type="checkbox"/> Acutane | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Cortisone |
| <input type="checkbox"/> High Blood Pressure Medication | <input type="checkbox"/> Thyroid Medication | <input type="checkbox"/> Retin-A (in the last 6 months) |
| <input type="checkbox"/> Any other Medications (please explain below) | <input type="checkbox"/> Glycolic Acid | <input type="checkbox"/> Alpha Hydroxy Acid |
- _____
- _____

Are you under the care of a Dermatologist? _____

Please indicate below the date of your most recent:

Tanning (Sun) _____	Chemical Peel _____
Tanning (Bed) _____	Waxing _____

Do not expose skin to the sun / indoor tanning for at least 48 hours after the waxing service.
I understand that I am accepting any reaction from a waxing service.

Client Signature _____