

Sycamore Day Spa Body Waxing Questionnaire

Thank you for giving us the opportunity to service you! Please take the time to fill out the following information about yourself. This information will help us give you better care and enable me to provide a safe service for you. All client information is kept confidential.

Name: _____ Date of Birth: ____/____/____
First Last

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

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Email: _____ Do you want to receive an email appt reminder 1-2 days before your appt? Yes or No
 We do not sell or give out your email

Whom may we thank for referring you?: _____

Waxing Questionnaire

Have you ever received waxing before? Yes or No Type & Frequency: _____

Do you have any questions about Waxing Services? _____

Have you had issues with waxing in the past? _____

Are you taking any Acne Medications? Yes or No (includes Accutane, Retin-A, Renova, Vit A, hydroquinone, etc)
 If Yes, What are you using? _____

Are you using any type of creams or exfoliants on your skin? Yes or No
 If Yes, What are you using? _____

Check all current and previous conditions:

SKIN CONDITIONS:

| Current | Past | Condition | Yes | No | Question |
|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Rashes | <input type="checkbox"/> | <input type="checkbox"/> | Are you ON (or a day or two near) your menstrual cycle? |
| <input type="checkbox"/> | <input type="checkbox"/> | Psoriasis | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any type of a Staph skin infection? Or diagnosed as a Staph carrier? |
| <input type="checkbox"/> | <input type="checkbox"/> | Warts or Moles (near waxing area) | <input type="checkbox"/> | <input type="checkbox"/> | Have you had your tonsils taken out? What year? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Fever Blisters/Cold Sores | <input type="checkbox"/> | <input type="checkbox"/> | Are you taking any blood thinners? |

ALLERGIES:

| Current | Past | Condition | Yes | No | Question |
|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Scents, lotions, oils | <input type="checkbox"/> | <input type="checkbox"/> | Is your waxed skin very red or itchy after waxing? Itchy <input type="checkbox"/> Red <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Detergents | <input type="checkbox"/> | <input type="checkbox"/> | Do you have issues with ingrown hairs? |
| <input type="checkbox"/> | <input type="checkbox"/> | Honey or Bees | <input type="checkbox"/> | <input type="checkbox"/> | Do you have children in your home under 6 years of age? |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | Are you in constant contact with children under 6 years of age? |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Have you had laser Resurfacing, chemical peels, surgery on your face, eyes or eyelids. |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Do you Tan regularly? |

I have informed them of all my known medical conditions and answered all questions honestly. I understand that Sycamore Day Spa therapists will only use and/or disclose my personal health information (PHI) for the purposes of carrying out treatment and evaluating the quality of services provided. Client PHI information will never be sold/given outside of Sycamore Day Spa. I have freely disclosed this information and have accepted and received the aftercare plan. I agree to keep the therapist performing services on me at Sycamore Day Spa updated as to any changes in my medical profile and understand that there shall be no liability to Sycamore Day Spa should I fail to do so. I consent to receiving services by therapists at Sycamore Day Spa.

Signature

Printed Name

Today's Date