



# Hair Removal Questionnaire & Consent Form

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Daytime Contact # \_\_\_\_\_ Evening Contact # \_\_\_\_\_

Would you like to receive notification of future promotions & specials? **Yes** **No** Email \_\_\_\_\_

Occupation \_\_\_\_\_ Significant Other \_\_\_\_\_

Birthday \_\_\_\_\_ Anniversary Date \_\_\_\_\_

Incase of Emergency, Please notify... Name \_\_\_\_\_ Telephone # \_\_\_\_\_

How did you hear of Warm Touch Body Spa?

Referral \_\_\_\_\_ (Did you know you get \$10 spa dollars as a THANK YOU for each referral)

Yellow Pages  YOU Magazine  Sign on Window  Gift Certificate/Card

Advertisement \_\_\_\_\_  Website \_\_\_\_\_  Other \_\_\_\_\_

When was the last time you shaved? \_\_\_\_\_ When is your menstrual cycle's start date? \_\_\_\_\_

\*\*\*Because of water retention & for your personal comfort, we suggest to avoid hair removal two days before your cycle starts & two days after.

**Do you have or are you prone to?**

Ingrown Hairs  Yes  No

Scarring  Yes  No

Bumps  Yes  No

Hyper-pigmentation  Yes  No

Bruising  Yes  No

Allergies  Yes  No

If yes, what to? \_\_\_\_\_

Have you used other skin thinning medications? If so, which?  
\_\_\_\_\_

Are you diabetic?  Yes  No

Have you ever been treated for cancer?  Yes  No

**Have you used any of the following in the last 48-72 hours?**

Accutane  Yes  No

Retin-A  Yes  No

Alpha-hydroxy Acid  Yes  No

Glycolic Acid  Yes  No

Resorcinol  Yes  No

Scrub or Peel  Yes  No

Have you used a tanning bed?  Yes  No

Any other illness/conditions you are presently being treated for by a medical professional? \_\_\_\_\_

I have read the above information and if I had any concerns, I have addressed them or will address them before my service with my esthetician. I give permission to my therapist to perform the hair removal 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 or using topically. I understand my esthetician will take every precaution to minimize or eliminate negative reactions. 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 Signature

\_\_\_\_\_  
Date