**Client Consultation form**

Name: Date of Birth:

Address:

Postcode:

Phone Number:

E-Mail:

**Please tick any of the below that may apply to you:**

Open wounds ( ) Pregnancy ( ) Allergies ( )

Asthma ( ) Verruca’s ( ) Eczema ( )

Epilepsy ( ) Cold Sores ( ) Rashes ( )

Psoriasis ( ) Sunburn ( ) Recent Scars ( )

Conjunctivitis ( ) Impetigo ( ) Ringworm ( )

Burns ( )

**Doctor’s permission must be sought before treatment if you have ticked any of the above boxes**

Are you on any medication taken orally or applied topically? If yes, please provide Details

Have you had a recent Skin peel, Microdermabrasion or are you using Glycolic based skincare? Or have you had any recent filler injections?

I confirm that the above information is true to the best of my knowledge and belief. I have been fully informed about the expected results and effects of waxing and agree to follow all aftercare advice provided by my therapist. I hereby give my consent to proceed with treatment.

Clients Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapists Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| Date | Treatment Details | Client / TherapistSignature |
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|  | Please sign here to confirm the details overleaf are correct and that no changes have taken place since you last treatment. |  |
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