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:_____

Date	Treatment Details	Client / Therapist Signature
	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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