Wax Consultation Form

Spa on the Hill
1007 E Street SE
Washington, DC 20003

Welcome to Spa on the Hill! We look forward to providing a therapeutic and enjoyable sanctuary for you to relax. Your therapist will use the information provided below to assess your needs and create a customized treatment plan for the duration of your visit. We invite you to place your phone on silent at this time and enjoy your visit.

Name _____ *Birthday* _____

*Phone*_____ *Email*_____

*Address*_____*City/State/Zip* _____

Referred By _____ *Emergency Contact* _____ *What is your usual method of hair removal?* _____

Do you normally experience ingrown hairs from hair removal? _____

Are you currently using Retin-A, Renova, Accutane or any other prescription medication for skin? _____

Do you use products containing enzymes, glycolic, AHA, or lactic acid? _____

(Female clients) When is your next menstrual cycle due to begin? _____

Always allow five days for menstrual cycle. Because of water retention and for your own personal comfort, you should avoid hair removal two days before your cycle is due and two days after it is completed.)

Please note that waxing does have certain side effects such as skin removal, redness, swelling, tenderness, etc. I have read the above information and if I have any concerns, I will address these with my skin therapist. I give permission to my therapist to perform the waxing procedure we have discussed and will hold her and her staff 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 as much as possible. I have read and understand the post-treatment home care instructions. I am willing to follow 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 the 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 and Date _____

Therapist Signature and Date _____