LOVE
SKINCARE CENTER
at Solera Salon and Spa

720.254.9234
8770 East Arapahoe Road
Centennial, Colorado 80112

Waxing Client Health and Consent Form

Date_____
First name_____ Last name_____ Middle Initial____
Phone number_____ Work _____ Cell_____
E-mail_____

1. Are you presently under a doctor's care? If yes, for what? _____
2. Are you currently taking any prescription medications? Yes__ No__
3. Are you presently taking any over-the-counter medications such as aspirin, Tylenol, Advil, etc? Yes__ No__
4. Please list ALL prescription and over the counter medications you are taking in the chart below. Specifically list any antibiotics, birth control, hormone replacement or blood thinners.

   Name of Drug Frequency

_____
_____
_____
_____

5. Please list all vitamins and food supplements you are taking in the chart below.

   Vitamins Food supplements

_____
_____
_____
_____

6. List all medications you are allergic to._____
7. Have you used Accutane in the last seven years? Yes__ No__
   if yes, when _____
8. Do you smoke? Yes__ No__
9. Have you had any alcohol or caffeine in the last 24 hours? Yes__ No__
10. Do you have autoimmune disease? Yes__ No__
11. Are you currently undergoing chemotherapy or radiation? Yes__ No__
12. Do you currently have any open lesions, acne, cold sores, cyst, boils, skin growths, inflamed skin, sunburn, peeling, cuts, moles, warts or active herpes virus.
13. What skin regimen are you currently using?

AM	PM
Cleanse_____	Cleanse_____
Renew _____	Renew _____
Moisturize_____	Moisturize_____
Sunscreen_____	Vitamin A, C, or Peptides_____
Eye cream _____	Masks or Scrubs _____

14. Do any of the products in your skin regimen contain the following ingredients?
    Retin-A__ Renova__ Deferin__ Glycolic Acid__ AHA__ Salicylic Acid__ Enzyme__ Scrubs__ Depilatory cream__

15. Have you ever had Laser treatments__? Peels__?

Please describe and give date(s)._____

16. Have you ever had an adverse reaction after using a skin regimen?
    Rash__ Irritation__ Peeling__ Sun Sensitivity__ Breakout__
17. Do you have: Diabetes__ Asthma__ Arthritis__ Hemophilia__ Cancer__
    High blood pressure__ Heart problems__
18. Have you been in a tanning bed within the last 48 hours? Yes__ No__
19. If this is not your first visit, has there been any changes in your overall health or medical condition since we last met? If yes please describe_____

I have answered all the questions to the best of my knowledge. I understand that because of certain health conditions I may not be a candidate for service today. I understand the risk associated with this procedure may include but are not limited to, discomfort, rash, swelling, irritation, redness, bruising or scarring. I have also received the appropriate post care instructions and understand that I may not receive the desired results if I do not comply with the post care instructions. By signing this form I give my consent to have this service and I release the aesthetician, medical director and Love Skincare Center, from any liability that may result from this treatment.

Signature_____ Date_____

Witness_____ Date_____