SUGAR QUESTIONNAIRE CLIENT FORM

Today’s Date \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_

Phone (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_--\_\_\_\_\_\_\_\_\_\_\_\_\_ Best way to remind you of your appt: CALL / TEXT / EMAIL

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? AD / INT / REF NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What body part are we sugaring today?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Design? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you last shave or trim? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you been waxed before? YES / NO When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any tendencies towards:

|  |  |  |
| --- | --- | --- |
| Ingrown hair YES / NO  | Hyperpigmentation YES / NO  | Eczema YES / NO  |
|  Break outs YES / NO  | Bruising YES / NO  |   | Psoriasis YES / NO  |
|  Bumps YES / NO Are you currently using or taking:  | Scarring YES / NO  |  |  |
| Isotretinoin/Accutane YES / NO  | Resorcinol YES / NO  |   | Indoor Tanning YES / NO  |
|  Retin-A YES / NO  | Glycolic Acid YES / NO  |   | Self Tanners YES / NO  |
| Alpha-hydroxy Acid YES / NO Medical Data: | Any Scrubs or Peels YES / NO  |  |  |
|  Herpes Virus YES / NO  | Staph/MRSA YES / NO  |   | Allergies YES / NOHPV YES/NO |

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that if I have Herpes or Staph/MRSA, HPV/Warts I may experience an outbreak after the waxing service. The professional has explained the best way to minimize or prevent an outbreak when waxing regularly. \_\_\_\_\_\_\_\_\_\_

I understand I may carry Herpes and/or Staph/MRSA without any physical symptoms or a medical diagnosis. I also understand that the waxing sugaring service does not allow the opportunity to contract these conditions from my technician. \_\_\_\_\_\_\_\_\_\_

I understand all of the above mentioned reactions. I also understand if I change my skin care routine or medications I must inform the professional PRIOR to any service in the future. \_\_\_\_\_\_\_\_\_ I understand that I must be showered and prepared for my service. \_\_\_\_\_\_\_\_\_

I understand that if I cancel or miss my appointment within the 24 hour cancellation policy I will be charged the full service fee\_\_\_\_\_\_\_\_

Waxing/Sugaring may cause bruising, pinpoint bleeding, lifting, hives or allergic reaction- welts, I understand this\_\_\_\_\_

All of the information within this form is correct to the best of my knowledge I agree that this Agreement is binding upon me, and my heirs, legal representatives and assigns. I represent that I am over 18 years of age and that I have the right to enter this agreement, or if I am under 18 years of age, I have had my parent or legal guardian consent to this agreement, and his or her relationship to me is as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. By his or her signature below, he or she ratiﬁes and consents to this

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| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Print Name     | Print Name  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Authorizing Signature Date**  | **Technician Signature Date**  |
|  |  |

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