

CLIENT CONSULTATION FORM

Professional hair removal consultation and screening

CLIENT INFORMATION

Client Name _____

Date _____

Phone _____

Email _____

Emergency Contact _____

Relationship / Phone _____

SERVICE INFORMATION

Area(s) to be treated _____

Practitioner _____

First visit? ☐ Yes ☐ No _____

Previous hair removal method _____

HEALTH & SKIN SCREENING

Please check any that apply now or have applied recently. Add details below when needed.

- | | |
|---|--|
| ☐ Pregnant or breastfeeding | ☐ Diabetes or blood sugar concerns |
| ☐ Bleeding / clotting disorder | ☐ Poor circulation or delayed healing |
| ☐ Skin condition, rash, infection, sunburn or open area | ☐ Cold sores / herpes in treatment area |
| ☐ Recent surgery or medical procedure | ☐ Allergy or sensitivity to skin products |
| ☐ Retinoid / retinol use | ☐ Prescription acne medication |
| ☐ Steroid or immune-suppressing medication | ☐ Blood-thinning medication |
| ☐ Recent chemical peel, laser, microneedling or dermabrasion | ☐ Recent tanning / significant sun exposure |
| ☐ Recent waxing, depilatory cream or other hair removal | ☐ Other health or skin concern |

CURRENT PRODUCTS & RELEVANT HISTORY

Medications / topical products currently used: _____

Known allergies / sensitivities: _____

Previous reactions to hair removal or skin treatments: _____

Additional notes or areas of concern: _____

PRACTITIONER ASSESSMENT

Service may proceed ☐ Yes ☐ No _____

Modification needed ☐ Yes ☐ No _____

Notes / modifications: _____

CLIENT CONFIRMATION

I confirm that the information I have provided is complete and accurate to the best of my knowledge. I will tell my practitioner about relevant changes before future services.

Client Signature _____

Date _____

Practitioner Signature _____

Date _____