THE LASH MONET

Waxing Consultation & Consent Form

Please complete this form honestly and thoroughly before your waxing service. Your answers help us determine whether waxing is appropriate and safe for you.

CLIENT INFORMATION

First Name _____	**Last Name** _____
Date of Birth _____	**Gender:** ☐ **Male** ☐ **Female** Other / Prefer not to say: _____
Email _____	**Phone Number** _____

WAXING HISTORY

Have you had waxing treatments previously? ☐ Yes ☐ No

Did you suffer any adverse reaction? ☐ Yes ☐ No

If yes, please describe:

Are you taking any medications? ☐ Yes ☐ No

If yes, please list:

If you check any condition below, waxing may be restricted or refused and you may be asked to consult your doctor before treatment.

Please check all that apply:

- ☐ Allergies
- ☐ High/low blood pressure
- ☐ Heart condition
- ☐ Epilepsy
- ☐ Radiotherapy
- ☐ Diabetes
- ☐ Varicose veins
- ☐ Hemophilia
- ☐ Cancer or recent cancer treatment
- ☐ Other: _____

Additional skin and treatment considerations:

- ☐ Pregnancy or nursing
- ☐ Recent chemical peel / laser / resurfacing
- ☐ Recent sunburn or tanning
- ☐ Active skin infection or open wound
- ☐ Retinol, retinoids, or acne medication
- ☐ Skin condition in treatment area

WAXING SERVICE REQUEST

WHAT WAXING SERVICES WOULD YOU LIKE?

☐ Eyebrow	☐ Underarm
☐ Chest	☐ Full leg
☐ Half leg	☐ Chin
☐ Back	☐ Upper lip
☐ Full face	☐ Bikini line
☐ Brazilian	☐ Other: _____

Specific area(s), preferences, or concerns:

CONSULTATION DATE & TIME

Consultation Date	Consultation Time
_____	_____

ANY ADDITIONAL REQUESTS

CLIENT ACKNOWLEDGMENT

Please initial each statement.

_____ I understand that waxing removes hair from the follicle by applying and removing wax from the skin.

_____ I understand that normal temporary reactions may include redness, warmth, tenderness, sensitivity, itching, or minor swelling.

_____ I understand that possible adverse effects include bruising, burns, skin lifting, skin tearing, bleeding, breakouts, ingrown hairs, folliculitis, irritation, allergic reaction, infection, temporary or permanent pigment changes and, in uncommon cases, scarring.

_____ I understand that waxing results vary and that no specific result or duration of hair removal has been guaranteed.

_____ I understand that certain medications, skincare products, medical conditions, and recent skin treatments may increase the risk of irritation, burns, skin lifting, or tearing.

_____ I confirm that I have disclosed all medications, topical products, allergies, medical conditions, and recent treatments that could affect my service.

_____ I understand that The Lash Monet may refuse, postpone, modify, or discontinue the service when the service provider believes waxing may be unsafe or inappropriate.

_____ I understand that waxing is a cosmetic service and does not diagnose or treat medical or dermatological conditions.

_____ I understand that I may ask questions, request an adjustment, or stop the service at any time.

_____ I understand that I should seek appropriate medical attention if I experience severe swelling, blistering, persistent pain, signs of infection, breathing difficulty, or another serious reaction.

_____ I agree to follow all verbal and written aftercare instructions provided by The Lash Monet.

I confirm that the information provided on this consultation and consent form is true and complete to the best of my knowledge. I understand that undisclosed conditions, medications, products, or recent treatments may increase the risk of skin irritation or injury. By signing below, I voluntarily authorize The Lash Monet to perform the waxing service(s) selected on this form.

Client Signature _____ **Date** _____

Parent/Legal Guardian Signature (required if client is under 18) _____ **Date** _____

SERVICE PROVIDER NOTES

Service Provider Signature _____ **Date** _____