



MODERN SALON & SPA

ESTHETICIAN PROFILE

Today's Date: _____

Name: _____

Height: _____ Weight: _____

Address: _____

City: _____ State: _____

Phone: _____

Email: _____

Birthday: _____

Referred by: _____ / _____ / _____

Emergency Contact Name & Number: _____

Pressure preference: LIGHT MEDIUM FIRM

Are you pregnant? YES NO

If yes, how many weeks? _____

CURRENT MEDICATIONS: *(Including vitamins, and/or herbs, both topical and internal. ex: Accutane, Retin-A, Renova, Tetracyline, Glycolic Acid, etc)*

MEDICAL CONDITIONS:
(ex: diabetes, high blood pressure, lupus)

ARE YOU UNDER THE CARE OF A DERMATOLOGIST? YES NO

Signature

Date

SKIN CHALLENGES: *(circle all that apply)*

OILY DRY SAGGING SKIN
ACNE AGING TEXTURE
PIGMENTATION DEHYDRATED BLACKHEADS / MILLA
DARK CIRCLES EYE WRINKLES SENSITIVITY / REDNESS

PLEASE INDICATE THE DATE OF YOUR MOST RECENT:

TANNING (BED) _____
TANNING (SUN) _____
CHEMICAL PEEL _____
MICRODERMABRASION _____
BOTOX _____
WAXING _____

HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY OF THE FOLLOWING?

ANIMALS SKINCARE FOODS
METALS METALS MEDICATION
COSMETICS POLLEN OTHER: _____

CURRENT REGIMEN: *(list all used)*

CLEANSER YES / NO _____
TONER YES / NO _____
SERUM YES / NO _____
EYE CREAM YES / NO _____
MOISTURIZER YES / NO _____
EXFOLIATION YES / NO _____

I have answered the above to the best of my knowledge and do release the Esthetician of any fault or liability following my services.

ESTHETICIAN USE ONLY

SpaBiz Notes:

Personal:

Goals:

Expectation:

Frequency of Visit:



MODERN SALON & SPA

WAXING WAIVER

Today's Date: _____

Name: _____

Address: _____

City: _____ State: _____

Phone: _____

Email: _____

Birthday: ____ / ____ / ____

Referred by: _____

CURRENT MEDICATIONS: *(Including vitamins, and/or herbs, both topical and internal. ex: Accutane, Retin-A, Renova, Tetracycline, Glycolic Acid, etc.)*

INITIAL

_____ *I understand as an alternative for sensitive skin, hard wax or threading may be available.*

_____ *Do not expose the skin to sun / indoor tanning for at least 48 hours after the waxing service.*

_____ *I have answered the above to the best of my knowledge and do release the Esthetician of any fault or liability following my services.*

Signature
Date

MEDICAL CONDITIONS: *(circle all that apply)*

- DIABETES
- DERMAL ABRASIONS
- HIGH BLOOD PRESSURE
- HERPES SIMPLEX
- WARTS
- OTHER: _____

PLEASE INDICATE THE DATE OF YOUR MOST RECENT:

- WAXING _____
- TANNING (BED) _____
- TANNING (SUN) _____
- CHEMICAL PEEL _____
- MICRODERMABRASION _____
- BOTOX _____

ARE YOU UNDER THE CARE OF A DERMATOLOGIST?

YES NO

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING AFTER A WAXING SERVICE?

- HIVES
- SKIN REMOVAL
- REDNESS *(Lasting longer than 24 hours)*
- BRUISING
- BREAK OUT

ESTHETICIAN USE ONLY

SpaBiz Notes:

Personal:

Area of Hair Removal:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Method of Hair Removal:

Frequency of Visit: _____