Electrolysis Client Intake Form

Please complete and bring this form to your first visit. If you have any questions, contact me via text at 512-618-1313 or via email at contact@behairfreetx.com.

PLEASE PRINT

First Name: _____ Last Name: _____

Date of Birth(*mm/dd/yyyy*): _____ Phone Number: _____

Email: _____ May I contact you via text at this number? □Yes □No

Address: _____

Emergency Contact:

Full Name: _____ Phone Number: _____

Gender (check all that apply):

□ Male □ Female □ Non-Binary □ Transgender □ Other

Preferred Pronouns (he/him, she/her, they/them, etc.): _____

How did you find us? _____

For which facial/body area(s) are you seeking electrolysis treatment?

_____

Which of the following hair removal methods have you used on your desired treatment area? (check all that apply)

□ Electrolysis □ Shaving □ Tweezing □ Bleaching □ Threading □ Sugaring

□ Depilatory creams (i.e. Nair) □ Laser hair removal □ Other: _____

Are you currently under a physician's care for reasons other annual wellness exams? If so, explain.

_____

_____

Current medications, including supplements and hormonal treatments:

_____

Do you have any allergies to skincare ingredients, medications, latex or anything else? If so, explain.

_____

Check all conditions (past and present) that apply:

□ Acne □ Allergies □ Cardiovascular disease □ Breathing problems □ Cancer

□ Currently pregnant □ Currently breastfeeding □ Cold sores/Fever blisters □ Diabetes

□ High blood pressure □ Keloid scars □ Hepatitis □ Herpes □ HIV □ TB

□ Polycystic Ovarian Syndrome (PCOS) □ Skin healing problems □ Metal implants

□ Hemophilia/other blood clotting disorders □ Body Piercings (in treatment area)

□ Pacemaker □ Warts (in treatment area) □ Anxiety/Panic attacks □ Seizures

□ Rosacea □ Recent Cosmetic injections □ Accutane treatments (within the last year)

□ Retin-A/Retinol skin care treatments (current) □ Bruises easily □ None of the Above

□ Other Condition(s): _____

When was your last physical exam? (*mm/dd/yyyy*): _____

Client Agreement

All health information on this form is accurate and complete to the best of my knowledge. I agree to update my health history by informing my electrologist, in writing, whenever there are changes.

Cancellation/No-Show Policy:

We require at least 24-hour notice for all canceled appointments. Appointments canceled/rescheduled after this 24-hour window will be charged **100%** of the scheduled service fee. Clients who "no call/no show" will be charged **100%** of the scheduled service fee. Clients who arrive late will be charged for the full appointment time booked, regardless of arrival time. Thank you for respecting these policies in order to keep my business prompt and professional.

_____

Signature **Date**