Breeze

SKINCARE & ELECTROLYSIS

Confidential Client Intake Form

Please complete this form. It will allow us to properly assess your personal needs and ensure your well being and safety. This information is confidential and will not be used for any other purposes.

Full Name_____

Date_____

Phone Number_____

Email_____

DOB_____

Have you had previous electrolysis treatments? YES NO

Date of first treatment:_____

Areas worked on:_____

Desired treatment area(s):_____

What temporary methods of hair removal do you use for area(s) of treatment?
Wax Tweeze Depilatory Cream Shave Other

Circle below if you have ever had, or been treated for any of the following conditions…

Diabetes	Herpes	Low Blood Pressure
Bleeding/Clotting Disorder	STD's	Vertigo
Chemo/Radiation	Pacemaker	Epilepsy
Tuberculosis	Adrenal Gland Disease	HIV
Circulatory Problems		Thyroid Disease
Cancer		Polysystic Ovary Syndrome