Renew Day Spa
Renew your mind, body & soul

Manicure/Pedicure Confidential Client Consultation & Health History

Date: _____

Name: _____ Date of Birth: _____

Address: _____ZIP_____

Home Phone: _____Business Phone: _____Cell Phone: _____

E-mail address: _____*(email address will be used for appointment reminders and our specials email list)*

Single: _____ Married: _____ If married, anniversary date: _____

Employer: _____Occupation: _____Referred by: _____

Your Skin

1) Do you have any open wounds, treated for a nail fungus, or think you may have one?_____ No _____ Yes

If yes, please explain

2) Have you recently used any self-tanning lotions, creams or treatments? _____ No _____Yes

3) Did you shave in the last 24 hours on your legs? (best not to shave prior to a pedicure)____No_____Yes

4) How frequently are you exposed to the sun or use a tanning bed? ___Infrequently ____Frequently ___Regularly

5) Have you ever had an allergic reaction to any of the following?

_____Cosmetics _____AHAs _____Medicine _____Fragrance _____Food _____Shellfish _____Animals_____Pollen
_____Latex _____Acetone _____Drugs _____Iodine Other_____

6) Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

Rash Irritation Peeling Sun Sensitivity Breakout

What Products?_____

7) Have you had a reaction to any manicures or pedicures in the past? _____ No _____Yes

If so please explain_____

Your Health

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year? _____ No _____Yes

If yes, please explain: _____

2) Have you had any of these health conditions in the past or present? (Please check all that apply)

_____Cancer
_____Depression
_____High blood pressure
_____Spinal injury
_____Thyroid condition
_____Diabetes
_____Heart problem
_____Varicose veins
_____Arthritis
_____Asthma
_____Epilepsy
_____Seizure disorder
_____ Skin disease/skin lesions
_____ Systemic disease
_____ Hepatitis
_____ Any active infection
_____ Immune disorders
_____ Lupus
_____ Metal bone pins or plates
_____ Phlebitis, blood clots, poor circulation
_____ Blood clotting abnormalities
_____ Psychological treatment
_____ Stroke

3) Are you currently taking any Medications that would hinder circulation or make you sensitive to products or bruise easily?/_____

Late arrival and Cancellation Policy

Please give at least 24 hour notice for any appointment changes or cancellations. Notices less than 24 hours will result in the full charge of your appointment. Late arrivals will reduce your treatment time so plan to be a few minutes early to enjoy your full treatment time.

Full Disclosure statement

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform my nail technician of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or nail technician from liability and assume full responsibility thereof.

Client Printed Name: _____

Client Signature: _____ Date:_____

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