Client Consultation Form

Name:_____

Email Address:_____

Are you on any blood thinners: Yes or No

How many Nail Salons have you been to in the last 90 days?_____

Do you have foot fungus OR have you ever had foot/nail fungus?_____

Are you currently treating foot fungus or nail fungus?_____

Do you have any communicable infections that need to be made aware of?_____

Have you had any recent hand or foot surgeries? Yes or No

If you are on Dr's orders; has your physician given you permission to get nail/pedicure services? Yes or No

Are you diabetic? Yes or No

Do you have any allergies and if so, what are you allergic to? Yes or No

Are you pregnant? Yes or No

I confirm that I give ___***The Traveling Pedicurist***____my consent to carry out nail treatments and that the information given above is correct to the best of my knowledge. I will follow the verbal and written aftercare advice given to me.

Client signature_____ **Date**_____