



## Pedicure, Massage & Waxing Services

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email Address: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### Medical History: Do you suffer from any of the following?

Arthritis	Yes No	High Blood Pressure	Yes No	HIV/AIDS	Yes No
Diabetes	Yes No	Eczema/Psoriasis	Yes No	Stroke	Yes No
Cancer	Yes No	Athletes Foot	Yes No	Pregnancy	Yes No
Blood Clots	Yes No	Numbness/Tingling	Yes No	Heart Disease	Yes No
Hepatitis A,B,C	Yes No	Infectious Disease	Yes No	Fungal Nails	Yes No

**Allergies to environmental/medications/herbal products** Yes No  
*(Especially nut allergies as some products contain traces of nuts)*

If yes please list: \_\_\_\_\_

### Have you ever been treated by a Dermatologist?

If yes please explain: \_\_\_\_\_

### Current medications including vitamins and herbal products:

Please list: \_\_\_\_\_

**Have you ever had a nail infection?** If yes, please explain: \_\_\_\_\_

### Do you have any of the following (please circle)?

Calluses      Corns      Ingrown Nails      Warts      Open Wounds      Tenderness

### Do you have any concerns you would like to discuss with your salon professional?

\_\_\_\_\_

## Consent to Treatment

I confirm that the information I have provided is accurate and complete. I have not withheld any information that may be relevant to my treatment and/or the results thereof. I have completed the questions above to the best of my knowledge and will inform the esthetician of any changes. I am aware that certain conditions regarding my health may prevent me from receiving certain treatments. **I have been informed that 24 hours notice of cancellation of service is required.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

If under 16: \_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Parent/Guardian Signature