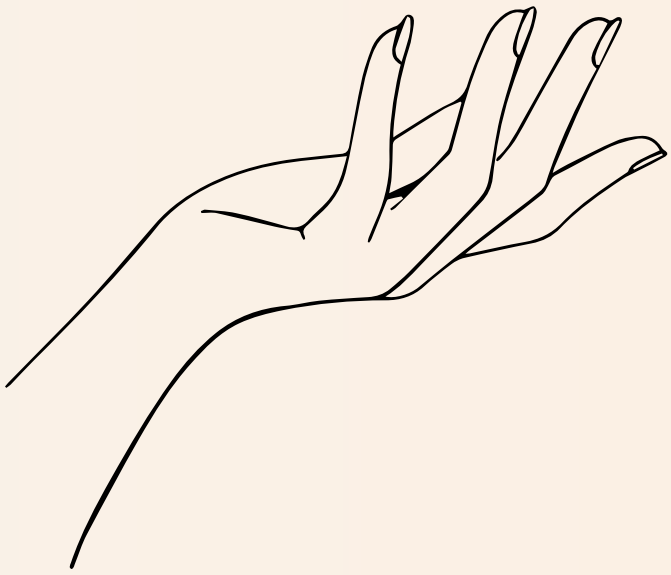
NAIL TECHNICIAN

RECORD BOOK



CLIENT NAME:

NAIL TECHNICIAN
CLIENT INTAKE FORM

CLIENT INFORMATION

Name: _____ Date: 24/01/93

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ NB

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone #: _____

How did you hear about us? _____

Would you like to be added to our email list for news and exclusive offers? *Yes* ☐ *No* ☐

MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select them:

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Thyroid Problems
- ☐ Circulatory or Muscular Disease
- ☐ Hypertension
- ☐ Cancer
- ☐ Brittle Nails
- ☐ Eczema
- ☐ Cuts/Abrasions
- ☐ Bitten Nails
- ☐ Warts
- ☐ Discoloration
- ☐ Poor Circulation
- ☐ Nail Slitting/Cracked
- ☐ Fungus infection
- ☐ Other: _____

Do you have any allergies: ☐ No ☐ Yes _____

List any medications/supplements you are currently taking: _____

_____

NAIL TECHNICIAN

CLIENT INTAKE FORM

CLIENT HISTORY

Have you had a professional nail treatment before? ☐ No ☐ Yes

If yes, what kind nail treatment did you do? _____

How often do you get professional nail treatment? _____

Do you do household cleaning, gardening or dish washing by hand? ☐ No ☐ Yes

On your hands, do you have: Open Wounds, Cuts, Sores Bruises, Tenderness? ☐ No ☐ Yes

If yes, please explain _____

Do you have history of picking or biting at your nails or cuticles?

☐ Always ☐ Sometimes ☐ Rarely ☐ Never

How would you describe your current nails condition:

☐ Split ☐ Peeling ☐ Crack ☐ Break ☐ Too Soft ☐ Too Hard ☐ Normal

Have you ever had or do you now have a nail infection on any of your fingernails or toenails? ☐ No ☐ Yes

If yes, please explain _____

Have you ever had an allergic reaction to any type of nail enhancement or other nail related products? ☐ No ☐ Yes

Are you currently taking any medication, whether prescribed or over-the-counter? ☐ No ☐ Yes

If yes, please describe _____

Do you play any sports that take a toll on hands or feet? ☐ No ☐ Yes

Do you suffer from autoimmune disorders of any kind? ☐ No ☐ Yes

Are you preparing for a special occasion? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes

Is there any other additional information you would like mention before the treatment? ☐ No ☐ Yes

NAIL TECHNICIAN
CLIENT CONSENT FORM

I hereby consent to and authorize _____ to perform the following procedure: _____

- [ ] I acknowledge that side effects can occur and I fully accept the risk. I understand that my Nail Technician, will take every precaution to minimize or eliminate negative reactions as much as possible. I will consult my Nail Technician first should I have any complications after receiving my treatment. I have been given the opportunity to ask questions and any questions have been answered to my satisfaction.

- [ ] I have read the information and recorded my medical history accurately with all pertinent information. For future services, I agree to inform my spa technician of any changes in my medical status and/or the above information. I understand spa services are not to be considered medical treatment, and as such, the Nail Technician cannot prescribe treatment of pharmaceuticals.

- [ ] I agree that my Nail Technician may determine that it is unsafe for you to continue a treatment due to health related concerns. In this event you may be required to provide a medical release from your physician prior to continuing treatment.

- [ ] I confirm that the information given above is correct, and that to my knowledge, I have not withheld any information that may be deemed relevant to the treatment I am receiving. I take responsibility for any side effects should they occur. I consent to the Nail Procedure with the understanding that it is an elective procedure, no medical claims are expressed. I will follow the verbal and written aftercare advice given to me.

By signing below, you agree to the following:
I have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition/s that would make the requested treatment unsuitable. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation of my health.

_____ _____

Technician (signature) *Client Name (signature)*

_____

Date

NAIL TECHNICIAN
TREATMENT RECORD

CLIENT INFORMATION

Name: _____ Date: _____

Phone: _____ Mail: _____

SERVICE DESCRIPTION

NAIL SHAPE

TECHNICIAN NOTES

NAIL CONDITION

B: Bitten
F: Fungus
IN: Infected
N: Normal
BR: Broken
L: Lifted

LEFT HAND	RIGHT HAND
Thumb	Thumb
Index	Index
Middle	Middle
Ring	Ring
Little	Little

PRICING

SERVICE:

TOTAL:

NAIL TECHNICIAN

CLIENT RECORD

Date	Treatments	Products	Notes	Price

NAIL TECHNICIAN

PHOTOGRAPH AND VIDEO RELEASE FORM

CLIENT INFORMATION

Name: _____ Date: _____

Phone: _____ Mail: _____

I would like your permission to use these photos for advertising. For example: Portfolios, online and print ads, etc. Your consent is necessary regarding this. Please circle and indicate with your signature if you would like your photos used or not used in advertising. We also like to tag our clients in photos used on our Instagram profile! Please indicate if you'd like to allow this or not below.

- ☐ Yes, feel free to use them
- ☐ Yes please tag me on Instagram
- ☐ No, please do not use them
- ☐ No, please do not tag me

_____ _____

Client Name (printed signature) *Client Name (signature)*

_____

Date