



NAIL CLIENT PROFILE & HISTORY

In order to provide you with the best products and service, please complete the following:

Name: _____ Date of Upcoming Service: _____

Phone: () _____

Address: _____

City & State: _____ Zip: _____

Email: _____ Referred by: _____

Physician's Name & Telephone: _____

Are you currently under the care of a physician? Yes No [please circle one]

Date of last visit to Physician: _____

Medications that you are currently taking: _____ (blood thinners, aspirin, etc)

Your current physical health is: Good Fair Poor [please circle one]

Do you have any allergies? Yes No [please circle one] If "YES", please explain:

Please list any medical conditions we should be aware of, such as diabetes, Hepatitis, AIDS, etc.:

I have reviewed the information on this profile and it is accurate to the best of my knowledge. I understand that this information will be used by the nail professional to help determine appropriate nail products and services. If there is any change in my medical status, physical condition, or medication, I will notify the nail professional. To the extent permitted by law, I understand the nail technician will keep this information confidential.

Signature: _____ Date: _____