

# The Gelle'On Retreat - Client Consultation Form

## Client Information

Full Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Emergency Contact (Name & Number): \_\_\_\_\_

## Health & Wellness

Please tick if you currently have or have had any of the following:

☐ Diabetes    ☐ Allergies (e.g. latex, gel, acrylic, etc.)    ☐ Skin Conditions (e.g. eczema, psoriasis)

☐ Circulatory issues    ☐ Pregnant or breastfeeding    ☐ Other: \_\_\_\_\_

## Nail & Skin History

Have you ever had a reaction to nail or skincare products?   ☐ Yes   ☐ No

If yes, please provide details: \_\_\_\_\_

\_\_\_\_\_

Do you currently have any cuts, infections, or damage to your hands or nails?   ☐ Yes   ☐ No

## Treatment Preferences

Treatment/s interested in:

☐ Gel Manicure    ☐ Acrylic Extensions    ☐ Pedicure    ☐ Press-On Nails    ☐ Other: \_\_\_\_\_

Preferred appointment days:   ☐ Wednesday   ☐ Thursday   ☐ Friday

## Consent

- I give permission for treatment to be carried out based on the information provided.
- I understand results may vary based on individual health, lifestyle & aftercare.
- I consent to before/after photos being taken for records and possible social media use.

☐ Yes   ☐ No

## Declaration

I confirm all information provided is true and accurate to the best of my knowledge.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_