

K – Beauty & Aesthetics LTD / Nail Treatment

Client Consultation Form:

Date:

Full Name:

Age:

Address:

Email:

Mobile:

How did you hear about us?.....

IN ORDER FOR ME TO PROVIDE THE BEST SERVICE FOR YOUR NAILS PLEASE ANSWER THE FOLLOWING QUESTIONS:

Are you preparing the nails today for any special occasion?.....

How would you like your finger and toe nails to be different than they are today?.....

What do you do for a living? Please provide as much information as you can: your occupation, sport activities, hobbies such as cooking, sewing, gardening

If this is your subsequent nail treatment when was the last one?.....

How often do you do your nails?

Do you use professional nail service to remove your nail set?.....

Are you happy for me to take a short video of my work as well as photos of your nails before and after your treatment?

YES NO

MEDICAL HISTORY: Please answer YES or NO

Do you have a history of any of the following:

Covid 19 (if so when) –

Have you had first dose of Covid 19 Vaccine (if so when) –

Have you had second dose of Covid 19 (if so when) -

Verruca -

Allergies –

Sensitivity to any cosmetics (ingredients) –

Thyroid Problems –

Hypertension –

Cancer –

Heart /Circulatory disease

Epilepsy –

Panic attack –

Client Signature:

Nail Tech Signature:

Karolina Addae

*T&C – You have read and agreed to Privacy Policy that is on www.kbeautyaesthetics.co.uk

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