5500 E Cheryl Pkwy Ste. 126
Fitchburg, WI 53711
608-255-0070
KNEADEDRELIEFDAYSPA.COM

Madison's First and Only
Destination Wellness Spa

CONFIDENTIAL CLIENT INFORMATION - NAIL

Name:_____ Date of Birth:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone Number (home)_____ (cell)_____ (work)_____
Email Address:_____
Current Occupation:_____
Height: _____ Weight_____ Shoe Size:_____ Robe Size: _____
How did you hear about us? _____
From a Friend, please provide his/her name: _____
Confirmation preference (please circle): Home Cell Email
Primary Physician & Phone:_____
Emergency Contact:_____

Do you have any condition that could affect service options for example, diabetes or other circulation disorders, slow healing, sensitivity to any cosmetic ingredient, currently pregnant?_____

_____

_____

Please list any known allergies:_____

Please list ALL medications you take, including oral, topical, blood thinners, pain relievers, etc: _____

_____

Have you ever had or do you now have a nail infection/fungus on either your fingernails or toenails? Yes or No
Please explain:_____
**If currently yes, we will not be able to proceed with nail service due to WI state sanitation statutes.

FOR QUESTIONS BELOW PLEASE, CIRCLE ALL THAT APPLY:

Do your nails:	Split	Peel	Crack	Break	
Are your nails:	Too Soft	Too Hard			
Are your cuticles ever:	Dry	Torn	Ragged	Inflamed	Red
On your hands/feet, do you have:	Calluses	Corns	Ingrown Nails	Warts	Athlete's Foot
Does the skin on your hands/feet ever:	Crack	Break open	Bleed		
On your hands or feet, do you have:	Open Wounds	Cuts	Sores	Bruises	Tenderness

What products do you currently use on your hands, nails, and feet? _____

_____

_____

How would you like your nails, hands, and feet to be different than they are today? _____

_____

Are there any special concerns you would like to discuss with your nail technician?_____

_____

_____

PLEASE CIRCLE ANY HEALTH CONDITIONS BELOW THAT APPLY TO YOU NOW OR IN THE PAST:

Anemia	Depression	Insomnia
Anxiety/Panic Attacks	Diabetes	Jaw Pain/TMJ
Arthritis _____	Digestion Issues	Knee Pain
Arm/elbow/wrist pain	Eczema	Neck/Shoulder Pain
Asthma	Fainting	Numbness/tingling
Back pain	Fibromyalgia	Osteoporosis
Blood clots	Gout	Pacemaker
Bone Disease or disorder	Headaches/Migraines	Paralysis
Broken Bones	Heart Attack	Post-Traumatic Stress Disorder
Bruise easily	Hearing Aids	Rosacea
Bursitis	Hepatitis:_____	Sciatica
Cancer:_____	Heart Problems/disease	Scoliosis
Cardiac Problems	High/Low Blood Pressure	Seizures
Circulatory Problems	Hip/Leg Pain	Stroke
Claustrophobia	HIV/AIDS	Surgery:_____
Chronic Fatigue Syndrome	Implants:_____	Thyroid: _____

Further explanation for any of above conditions or other conditions not listed:_____

_____

_____

_____

Cancellation Policy: If you must cancel we ask for a 48 hour notice, so that we may offer that appointment to someone on our waiting list. In the event of a cancellation less than 48 hours, there will be a charge for 50% of the treatment cost. In the event of a missed appointment ("no show"), there will be a charge for 100% of the treatment cost. We do understand that emergencies arise and weather conditions may become hazardous. Please call us so that we are aware of your situation.

Kneaded Relief would like to ensure you that your spa visit is exactly what you request. Please be aware that a consultation with your therapist will be a part of your service and is included within the service time. The therapist must be made aware of any existing physical and mental condition; hence I have stated all my known medical conditions. I take it upon myself to keep them updated on my physical and mental health, conditions and concerns, and understand that there shall be no liability on the therapist's or Kneaded Relief's part should I fail to do so. I understand that certain medical issues may contraindicative and may be referred to a medical professional. I understand that communication is an essential part of my treatment and agree to tell my therapist if I am uncomfortable, want less pressure or need more. I also understand that any sexual suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment in full. By signing below I am agreeing to these terms.

Signature:_____ Date:_____