

Client Consultation Form

iUBT377 – Airbrush designs for nails

College name:	
College number:	
Learner name:	
Learner number:	
Date:	

Client name:		
Address:		
Profession:		
Telephone number:	Day:	
	Evening:	

Personal details:						
Age group:	Under 20 <input type="checkbox"/>	20 – 30 <input type="checkbox"/>	30 – 40 <input type="checkbox"/>	40 – 50 <input type="checkbox"/>	50 – 60 <input type="checkbox"/>	60+ <input type="checkbox"/>
Lifestyle:	Active <input type="checkbox"/>			Sedentary <input type="checkbox"/>		
Last visit to the doctor:						
GP address:						
Number of children: (If applicable)						
Date of last period: (If applicable)						

Contra-indications requiring medical permission – in circumstances where medical permission cannot be obtained clients must sign an informed consent form stating that the treatment and its effects have been fully explained to them and confirm that they are willing to proceed without permission from their GP – *(Select if/where appropriate):*

Any condition already being treated by a GP, dermatologist or another practitioner <input type="checkbox"/>	Acute arthritis <input type="checkbox"/>	Nervous or psychotic conditions <input type="checkbox"/>
Recent operations on the area <input type="checkbox"/>	Undiagnosed pain <input type="checkbox"/>	Acute rheumatism <input type="checkbox"/>
Asthma <input type="checkbox"/>		

Contra-indications that restrict treatment – *(Select if/where appropriate):*

Fever <input type="checkbox"/>	Infectious or contagious diseases <input type="checkbox"/>	Infectious or contagious diseases of the skin and nails <input type="checkbox"/>
Under the influence of recreational drugs or alcohol <input type="checkbox"/>	Diarrhoea and/or vomiting <input type="checkbox"/>	Any known allergies <input type="checkbox"/>
Undiagnosed lumps and bumps <input type="checkbox"/>	Inflammation <input type="checkbox"/>	Cuts <input type="checkbox"/>
Bruises <input type="checkbox"/>	Abrasions <input type="checkbox"/>	Scar tissue (2 years for major operations and 6 months for a small scar) <input type="checkbox"/>
Recent fractures (minimum 3 months) <input type="checkbox"/>	Sunburn <input type="checkbox"/>	Repetitive strain injury <input type="checkbox"/>
Carpal tunnel syndrome <input type="checkbox"/>	Loss of skin sensation <input type="checkbox"/>	Severely bitten/damaged nails <input type="checkbox"/>
Nail separation <input type="checkbox"/>	Eczema <input type="checkbox"/>	Psoriasis <input type="checkbox"/>
Dermatitis <input type="checkbox"/>	Broken bones <input type="checkbox"/>	Warts <input type="checkbox"/>
Verrucae <input type="checkbox"/>		

Nail test:

Natural nail shape:	Fan <input type="checkbox"/>	Hook <input type="checkbox"/>	Oval <input type="checkbox"/>	Pointed <input type="checkbox"/>
	Round <input type="checkbox"/>	Ski jump/spoon <input type="checkbox"/>	Square <input type="checkbox"/>	
Moisture content:	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
Cuticle condition:	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
Skin condition:	Dehydrated <input type="checkbox"/>	Dry <input type="checkbox"/>	Normal <input type="checkbox"/>	
Skins healing ability:	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
Circulation:	Good <input type="checkbox"/>	Normal <input type="checkbox"/>	Poor <input type="checkbox"/>	
Overall nail/cuticle condition:				

Area to be treated:Toe nails ☐Finger nails ☐**Treatment details** (to include details of design and products used):**Photographs** (before and after):**Client feedback:**

Aftercare/home care advice given:

Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	03/12/2019	First published	Qualifications Administrator