

Client Consultation Form

iUBT384 – Nail art

Centre name:	
Centre 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 give their informed consent in writing prior to treatment (Select if/where appropriate):

Transverse ridges	<input type="checkbox"/>	Hang nail	<input type="checkbox"/>	Mould	<input type="checkbox"/>
Vertical ridges	<input type="checkbox"/>	Lamella dystrophy	<input type="checkbox"/>	Warts	<input type="checkbox"/>
Beau's line	<input type="checkbox"/>	Onychomycosis (tinea unguium)	<input type="checkbox"/>	Verruca	<input type="checkbox"/>
Blue nail	<input type="checkbox"/>	Onychoptosis	<input type="checkbox"/>	Loss of skin sensation	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	Onychatrophia	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	Onychauxis	<input type="checkbox"/>	Allergies	<input type="checkbox"/>
Paronychia (Whitlow)	<input type="checkbox"/>	Onychorrhaxis	<input type="checkbox"/>	Corns	<input type="checkbox"/>
Sepsis	<input type="checkbox"/>	Onychogryphosis	<input type="checkbox"/>	Chilblains	<input type="checkbox"/>
Leukonychia	<input type="checkbox"/>	Onychogryposis	<input type="checkbox"/>	Cuts	<input type="checkbox"/>
Flaking	<input type="checkbox"/>	Onycholysis	<input type="checkbox"/>	Abrasions	<input type="checkbox"/>
Dry/brittle nails	<input type="checkbox"/>	Onychocryptosis	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>
Pitting	<input type="checkbox"/>	Koilonychia	<input type="checkbox"/>	Discolouration	<input type="checkbox"/>
Pterygium	<input type="checkbox"/>	Onychophagy	<input type="checkbox"/>	Severely bitten nails	<input type="checkbox"/>
Onychia	<input type="checkbox"/>	Onychophyma	<input type="checkbox"/>	Severely bitten/picked skin around the nail	<input type="checkbox"/>

Nail test – (Select if/where appropriate):

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 – (Select if/where appropriate):

Toe nails <input type="checkbox"/>	Finger nails <input type="checkbox"/>
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Treatment details – *(To include products used):*

Treatment details – *(To include products used):*

Client feedback:

Aftercare feedback:

Therapist/Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	29/10/2019	First published	Qualifications Administrator