Client Consultation Form

iUBT395 – Providing basic manicure treatment

Centre name:	
Centre number:	
Learner name:	
Learner number:	
Date:	

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

Personal details:						
Age group:	Under 20 ☐	20 – 30 ☐	30 – 40 ☐	40 – 50 ☐	50 – 60 ☐	60+ ☐
Lifestyle:	Active ☐			Sedentary ☐		
Last visit to the doctor:						
GP address:						

Nail test – *(Select if/where appropriate):*						
Contra-indications:	No	☐		Yes		☐
Skin condition:	Dehydrated	☐	Dry	☐	Normal	☐
Nail colour:	Pink	☐	Pale	☐	Blue	☐
Nail shape:	Oval	☐	Square	☐	Pointed	☐
	Almond	☐		Round		☐
Overall nail condition:						
Treatment to include (select where appropriate):	Fill the nails ☐	Buff the nails ☐		Base coat ☐		Light coloured nail polish ☐
	Top coat ☐	Clear nail polish ☐		Nail strengtheners ☐		Hand lotion ☐

Aftercare/home care feedback:

Therapist/learner signature: _____

Client signature: _____

Signature of senior member of staff: _____

Document History

Version	Issue Date	Changes	Role
v1	17/12/19	First published	Qualifications Administrator