Medi-Ped Spa
A union of health & beauty

Pedicure, Massage & Waxing Services

Name:_____ Date of Birth:_____ Occupation:_____

Address:_____ City:_____ Postal Code:_____

Phone:_____ Cell:_____

Email Address:_____ How did you hear about us?_____

Medical History: Do you suffer from any of the following?

Arthritis	Yes No	High Blood Pressure	Yes No	HIV/AIDS	Yes No
Diabetes	Yes No	Eczema/Psoriasis	Yes No	Stroke	Yes No
Cancer	Yes No	Athletes Foot	Yes No	Pregnancy	Yes No
Blood Clots	Yes No	Kidney Problems	Yes No	Heart Disease	Yes No
Hepatitis A,B,C	Yes No	Infectious Disease	Yes No	Fungal Nails	Yes No

Allergies to environmental/medications/herbal products Yes No
(Especially nut allergies as some products contain traces of nuts)

If yes please list:_____

Have you ever been treated by a Dermatologist?

If yes please explain:_____

Current medications including vitamins and herbal products:

Please list:_____

Are you on blood thinners? Yes No

Have you ever had a nail infection? If yes, please explain:_____

Do you have any of the following (please circle)?

Calluses Corns Ingrown Nails Warts Open Wounds Tenderness

Do you have any numbness or tingling in your feet? Yes No

Do you have any concerns you would like to discuss with your salon professional?

_____

Consent to Treatment

I confirm that the information I have provided is accurate and complete. I have not withheld any information that may be relevant to my treatment and/or the results thereof. I have completed the questions above to the best of my knowledge and will inform the esthetician of any changes. I am aware that certain conditions regarding my health may prevent me from receiving certain treatments**. I have been informed that 24 hours notice of cancellation of service is required.**

_____ _____

Client Signature Date

If under 16: _____ _____

Parent/Guardian Name Parent/Guardian Signature