Name _____Phone _____

Address _____

City _____State _____Zip _____

Email _____

How did you hear about Epic? _____

NAIL INTAKE

DOB____/____/_____

The following information is necessary to evaluate and meet your individual needs for professional services and home care maintenance. All Information collected is strictly confidential.

Do you have any condition that that could affect service options such as allergies, diabetes, any other circulation disorders, slow healing, or sensitivity to any cosmetic ingredients?

_____

Do you have any past injuries / medical conditions or are you on any medications that we may need to be aware of before performing your service(s) today?_____

Please indicate if you have any of the following medical conditions:

☐ Nail Fungus	☐ Asthma	☐ Claustrophobia	☐ Edema	☐ Varicose veins
☐ Cancer	☐ Arthritis	☐ Nail or skin infections	☐ Sinus problems	☐ Heart condition
☐ Pregnancy	☐ Diabetes	☐ Contagious Disease	☐ Thyroid Disorder	
☐ Seizures	☐ Eczema	☐ Hemophilia/bleeding	☐ Dislocated Joints	

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

_____

What services have you enjoyed in the past? How would you improve the experience? _____

_____

How would you rank your activity level? (circle one) 1 2 3 4 5 6 7 8 9 10

Do you play any sports that take a toll on your hands or feet?

_____

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

_____

Release of Liability

It is my choice to receive spa therapies. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update Epic Day Spa of any changes to my health status. I understand that Estheticians, Massage Therapists and Nail Techs do not diagnose illness, disease, or physical or mental disorders, nor do they prescribe medical treatments, pharmaceuticals, or perform spinal manipulations. I acknowledge that these treatments are not a substitute for medical examination or diagnosis, and that is recommended I see a primary health care provider for that service. If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24 hour notice, I agree to pay the missed appointment fee that applies.

I understand that any illicit or sexually suggestive behavior, remarks or advances made by me will result in the immediate termination of the session and I will be liable for payment of the scheduled service.

Guest signature_____**Date**_____