Altitude laser spa

PEDICURE INFORMATION FORM

Name: _____

Address: _____

Phone (Home): _____ (Cell): _____

Email: _____

Current Medications: _____

_____

Please Circle The Appropriate Below:

Are You Diabetic? YES NO

Do You Have Allergies? YES NO

With respect to your feet, which of these conditions do you experience?

CONDITION	NEVER	AT TIMES	USUALLY
Cold Feet			
Dry Skin			
Cracked Skin			
Itchiness			
Peeling Skin			
Sweating			
Hot Feet			
Blisters			
Skin Fungus			
Nail Fungus			
Discolored Nails			
Thick Nails			
Tired Sensation			
Heavy Sensation			
Foot Odor			
Callus Build Up			
Corns			
Planter Warts			

What improvements would you like to see?

_____

_____

Signature: _____ Date: _____