Client Record

Last Name: _____ FirstName: _____

Address/City: _____ Province: _____ Postal Code: _____

Date of Birth: _____ Parental Consent: Yes NA Date: _____

Email: _____

PLEASE CIRCLE ANY CONDITIONS LISTED BELOW THAT APPLY TO YOU:

TB	EPILEPSY	BLOOD THINNERS	SCARRING/KELOIDS
HIV	ASTHMA	ECZEMA/PSORIASIS	GONORRHEA/SYPHILIS
HEPATITIS	HEART CONDITION	MRSA/STAPH INFECTION	HERPES/WARTS
HEMOPHILIAOTHER	BLEEDING DISORDER	PREGNANT/NURSING	ALLERGIC REACTIONS TO LATEX
DIABETES	SKIN CONDITIONS	FAINTING OR DIZZINESS	ALLERGIC REACTIONS TO ANTIBIOTICS

Do you have any allergies? _____

Do you use any medications or have any medical/skin conditions that may affect the healing of the body art you wish to receive? (Blood Thinning Medication) _____

Is there any information you feel you should provide to the body artist?

_____

_____

_____

PROCEDURE:

Piercing Location of piercing:

Jewelry used including size, material composition, and manufacturer:

Body Artist Signature: _____ Client Signature: _____

Date_____

Attach to this page copies of clients ID and any packaging showing lot numbers, date sterilized, etc. from all instruments or equipment used during this procedure.