Client Record

Last Name: _____ **First Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

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

PLEASE CIRCLE ANY CONDITIONS LISTED BELOW THAT APPLY TO YOU

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

How long has it been since you last ate? _____

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? _____

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

_____

PROCEDURE:

Tattoo

Location of tattoo: _____

Colors, Manufacturer, and Lot Numbers of all inks used:

_____

_____

_____

_____

Piercing

Location of piercing: _____

Jewelry used including size, material composition, and manufacturer:

_____

_____

Body Artist Signature: _____ Client Signature: _____

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.