Client information: (Please print clearly)

Name: ______________________ Birth date: ______________

Address: ______________________ City: ______________

Province: __________ Postal Code: __________ Email: ______________

Home phone: __________ Work phone: __________ Cell phone: __________

Person to contact in case of emergency: ______________________

Relationship: ______________ Phone: ______________

How did you find out about us: ______________________

Medical History:

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever-received Gold Therapy?	☐	☐
3. Have you ever had laser treatment(s) in the past?	☐	☐

4. List any Medications you are currently taking. ______________________

5. List any allergies you may have. ______________________

6. Do you have or have ever had any of the following:

	Yes	No		Yes	No
Auto Immune Disease	☐	☐	Histamine Reaction	☐	☐
Cold Sores	☐	☐	HIV / AIDS	☐	☐
Dermatitis / Eczema	☐	☐	Keloid (thick) Scars	☐	☐
Diabetes	☐	☐	Latex Allergies	☐	☐
Hemophilia	☐	☐	Seizures / Epilepsy	☐	☐
Hepatitis	☐	☐	Pregnant	☐	☐

Skin Sensitivities:

Chemicals	☐	☐
Cosmetics	☐	☐
Fabrics	☐	☐
Other ______________		

How do you tan?

Very Good ☐ Good ☐ Not at all ☐ Self Tan Method ☐

How do you heal?

Very Good ☐ Good ☐ Slow ☐ Under Medical Control ☐

Tattoo's To Be Treated

	First Tattoo	Second Tattoo	Third Tattoo	Fourth Tattoo
Location of Tattoo	___________	___________	___________	___________
Age of Tattoo	___________	___________	___________	___________
Type of Tattoo:				
Professional	☐	☐	☐	☐
Homemade	☐	☐	☐	☐
India Ink	☐	☐	☐	☐
Other	☐	☐	☐	☐

____ Patient's Signature

_____________________ Date