MICRONEEDLING - PREPARATION

Avoid anticoagulants and blood thinning medications and supplements 4 days prior to treatment. If you are on a prescription medication, please speak to your doctor before discontinuing any medication.

Must not have new permanent make up or injectables on or near the treatment area. Please ensure you have allowed adequate time (at least 2 weeks) for any permanent make up or injectables to heal prior to microneedling.

Use sunscreen with an SPF 30 or more daily. Sun burnt skin can not be treated. Skin that is thin, sensitized or compromised in any way may not be treated until fully healed.

Sun exposure and/or use of tanning beds, including self tanning products must be avoided 24 before and after the treatment, preferably one week.

Avoid any irritating skin care ingredients, such as any products containing Hydroquinone, bleaching creams. Retin A, retinol, benzoyl peroxide, glycolic/salicylic acids or astringents for at least 3 days prior to treatment. Please advise your technician if you are currently using any prescription creams or products.

Do not tweeze or wax the area one week prior to the treatment. This can cause irritation and burns to the skin.

If you have any open cuts, wounds, abrasions or cold sore breakouts, we can not perform the procedure.

OPTIONAL PRE TREATMENT INSTRUCTIONS

Use cellular turnover treatment daily at night time for two weeks. Discontinue application week prior to treatment.

Apply vitamin C serum once daily for 2-3 weeks.

Eat a healthy diet and take omega 3 fish oil daily.

CLIENT INTAKE FORM

Date:_____ Date of Birth: _____.

First Name:_____ Last Name: _____.

Address: _____ City: _____ State: _____ Zip: _____.

Home Phone: _____ Cell Phone: _____ Email: _____.

Occupation: _____ Hereditary Background: _____.

How did you hear about us?

Have you seen a dermatologist in the past year? YES __NO___If so, list dermatologist's name and reason for the visit.

Have you been under the care of a physician during the last year? YES___NO___.
If so, please list the physician's name.

Do you use sunscreen? YES__NO__Sometimes__.

Have you ever had any of the following conditions? (circle if applicable)

Acne/HX of scarring	Tumors/growths/cysts	Melasma
Arthritis	Pacemaker/metal implants	History of implants
Diabetes	Hepatitis	Blood clots
Severe headaches/migraines	HIV / Aids	Bleeding disorder
Herpes/Cold sores/Fever blisters	Abnormal wound healing	Autoimmune disease
Seizures/Epilepsy	Keloid Scarring	Vascular Disease
Cancer	Skin Disorders	Bacterial Infection
Chemotherapy/Radiation	Hypopigmentation (lightening)	Fungal Infection
Thyroid Disease	Hyperpigmentation(darkening)	Recurrent Infections
Lupus	Vascular (vein surgery)	Laser treatments
Pregnant/nursing	Edema (swelling)	Cosmetic surgery

List any conditions not mentioned above:

How much water do you consume daily? _____.

How much caffeine do you consume daily? _____.

Do you currently have a sunburn, tan, red face or wind burn? _____.

Are you in the habit of using tanning booths or self tanner? If so, when was the last time?

Do you wear contact lenses or eyeglasses? _____.

Do you have an intolerance to heat or cold? _____.

Have you received any of the following treatments? (circle if applicable)

Chemical Peel	Facial ultrasound	Permanent Makeup
Microderm	Microneedling	Laser Treatments
Dermaplaning	Laser Hair Removal	Injectables
Intense Pulsed Light	Waxing	Tattoos
Professional Facial		

Have you had any other treatments? List here:

Have you ever used any of the following topical / oral medications?

Accutane	Avage	Topical antibiotics
Renova	EpiDuo	Hydroquinone
Differin	Alpha Hydroxy Acids (i.e. glycolic)	
Tazorac	Beta Hydroxy Acids (i.e. salicylic)	
Tretinoin	Retin A (retinol)	

Current medications (including over the counter):

Current dietary supplements including vitamins, herbs, etc.:

Do you smoke? If so, how much?_____.
Do you drink alcohol? If so, how often? _____.

Allergies (food, latex, dairy, seafood, aspirin, medications)? YES___NO__.

Explain:_____.
*reaction (shock, hives, rash, swelling)

Please list all products you are currently using on your skin throughout the day including your a.m. and p.m. routine:

Do you have any other concerns that have not been covered on this form?

Please indicate which areas you are interested in improving?

Sun spots/brown spots	Sagging skin	Rosacea
Melasma	Crepey skin	Sensitivity
Preventative Aging	Large pores	Acne
Wrinkle/Fine lines reduction	Tone/texture	Acne Scarring
Hypopigmentation	Broken capillaries	Skin care routine

Additional Comments:

I have freely and truthfully submitted my medical information. I understand it is my responsibility to report any updates or changes of my medical conditions to my provider prior to receiving treatments.

Client Signature: _____.

Print Client Name:_____ Date:_____.

MICRONEEDLING CONSENT

I understand that results will vary among individuals.
I understand that although I may see a change after my first treatment, I may require a series of sessions to obtain my desired outcome.
The procedure and side effects have been explained to me including alternative methods, as have the advantages and disadvantages.
I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of the treatment. I am aware that Micro-needling treatment is not permanent, as natural degradation will occur over time.
I state that I have read (or it has been read to me) and I understand this consent and I understand the information contained in it.
I have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure have been answered in a satisfactory manner.
This consent form is valid until all or part is revoked by me in writing.

Description of the Procedure

Micro-needling treatment allows for controlled induction of the skin's self-repair mechanism by creating micro-"injuries" in the skin, which triggers new collagen synthesis, yet does not pose the risk of permanent scarring. The result is smoother, firmer and younger-looking skin. Micro-needling procedures are performed in a safe and precise manner with the use of the sterile needle head. The procedure is normally completed within 30–60 minutes, depending on the required treatment and anatomical site.

Side Effects

After the procedure, the skin will be red and flushed in appearance in a similar way to moderate sunburn. You may also experience skin tightness and mild sensitivity to touch on the area being treated. This will diminish greatly after a few hours following treatments and within the next 2 to 7 days the skin will be completely healed. It is normal to experience dryness and peeling.

Contraindications

Micro-needling treatment is contraindicated for patients with: keloid scars, scleroderma, collagen vascular diseases or cardiac abnormalities, a hemorrhagic disorder or hemostatic dysfunction, active bacterial or fungal infection.

Precautions and Warnings

Micro-needling treatment has not been evaluated in the following patient populations, as such, precautions should be taken when determining whether to treat: scars and stretch marks less than one year old; women who are pregnant or nursing; keloid scars; patients with history of eczema, psoriasis and other chronic conditions; patients with a history of actinic (solar) keratosis; patients with history of herpes simplex infections; diabetics or patients with wound-healing deficiencies; patients on immunosuppressive therapy; and skin with presence of raised moles or warts or targeted area.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____