

Micro-Needling Consultation Form

Personal Details:

Name: _____ DOB: _____
 Address: _____

Email: _____ Contact Number: _____

Doctors Name & Address: _____

Medical Questionnaire:

Do you suffer from? (Please tick only those that apply)

- | | |
|--------------------------------------|--------------------------|
| Diabetes (GP) | <input type="checkbox"/> |
| Haemophilia (P) | <input type="checkbox"/> |
| Thrombosis (P) | <input type="checkbox"/> |
| Autoimmune ocnditions i.e lupus (GP) | <input type="checkbox"/> |
| Heart Problems (P) | <input type="checkbox"/> |
| Over/Underactive Thyroid | <input type="checkbox"/> |
| Hormonal Problems | <input type="checkbox"/> |
| Low/High Blood Pressure(GP) | <input type="checkbox"/> |
| Eczema (GP) | <input type="checkbox"/> |
| Skin Cancer, Radio/Chemotherapy (P) | <input type="checkbox"/> |
| Cold Sores | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> |

If yes please specify: _____

Are you currently taking any medication?

Yes No

Have you had any medical treatment within the last 6 months?

Yes No

If yes please specify: _____

Are you pregnant or breast feeding?

Yes No

Do you smoke?

Yes No

Skin History:

Have you had any of the following on the area to be treated in the last three months?

Laser Treatment

Yes No

Microdermabrasion/Chemical Peels

Yes No

Waxing or other form of hair removal

Yes No

Sun beds, Sun exposure or sun burn

Yes No

Other Aesthetic treatments (including botox dermal filler)

Yes No

If yes please specify: _____

Are you currently or have you used any of the following in the last 6 months?

Retinol A/Renova

Yes No

Vitamin C Products or Alpha Hydroxy Acids

Yes No

Skin Thinning Creams or Blood Thinning Medication

Yes No

Accutane / Roaccutane

Yes No

If yes please specify: _____

Pre Treatment Checklist to be completed by the therapist (tick to confirm points have been discussed)

- | | | |
|---|---|---|
| <input type="checkbox"/> How treatment works | <input type="checkbox"/> Pre/Post treatment care | <input type="checkbox"/> SPF advice |
| <input type="checkbox"/> Typical number of treatments/Intervals | <input type="checkbox"/> Likely outcome | <input type="checkbox"/> Sensation during treatment |
| <input type="checkbox"/> Possible side effects | <input type="checkbox"/> Cost per treatment _____ | <input type="checkbox"/> Photograph taken |

I _____ authorise _____ Therapist to perform Micro-needling treatment:

- This procedure involves application of the Micro-needling to the area which is a rolling device/pen with small needles; thus

creating mild trauma and a little discomfort to the area. A topical anaesthetic can be applied at home i.e. Emla to the skin approximately 30 minutes before the treatment begins. I will patch test my skin with the Emla.

- In order to receive optimal results, more than one treatment will be required, thus multiple treatments may be necessary to achieve best results and that there is no guarantee of permanent results. Typically 3-4 treatments are required for optimal results and at 6-8 week intervals and work best when combined with skin peel treatment.
- I understand that the results of the treatment and rate of improvement depends on my age, skin type and condition, degree of sun/environmental damage, pigmentation levels or acne condition and that a small percentage of people with not respond satisfactorily to the treatment.
- I will follow pre- and/or post treatment instructions and attend my appointments as scheduled; including avoidance of sun exposure, Laser/IPL treatments, home exfoliating, use of topical, abrasive scrubs and any medications that are contraindicated to receiving Micro needling including but not limited to Roaccutane, etc. I understand that I must not have used any of the medications including Roaccutane for at least 12 months prior to my Micro-needling treatment.
- I have been informed of some possible benefits, risks and complications which may include, but are not limited to: softer, smoother skin; reduction in the appearance of lines& wrinkles, scarring; reduction in acne lesions; swelling & redness; some bleeding; prolonged skin sensitivity to wind & sun; areas of persistent increased or decreased pigmentation. I understand the areas where there are raised moles, active acne, eczema and psoriasis will be avoided during the treatment. If I have skin infections, active cold sores I cannot be treated.
- Any potential risks and complications could result in the need to discontinue the treatment. I understand that, very rarely, permanent damage occurs. I also agree to immediately inform my therapist if I have concerns, or I am overly uncomfortable during treatment. I will notify my therapist if there are any changes in my medical history including any new medication or treatments and if I become pregnant prior to each treatment.
- I have had an opportunity to ask questions and have my questions answered to my satisfaction.
- I certify that I am over the age of eighteen (18), that I am not pregnant, trying to get pregnant or nursing, on Accutane, or taking any other medication that my therapist has told me may be contraindicated to having this procedure. I have read and will follow to the best of my ability any and all instructions. I understand the potential risks and complications and choose to proceed after careful consideration of the possibility of both known and unknown risks, complications, limitations and alternatives.
- I consent to a before and after photograph to be taken and held by the clinic indefinitely and be used by the clinic or any related companies for marketing purposes including but not limited to flyers, newsletters, portfolio and the internet (including but not limited to Websites, Instagram, Facebook, YouTube, etc.)
- I understand as per privacy policy my records and details including name, address, email and contact number will be stored securely for insurance requirements, after which they will be disposed of.

Do you wish to receive emails on our monthly offers and newsletters?

Yes

No

Do you wish to receive sms messages to remind you of your next appointment and offers?

Yes

No

Do you wish to receive mail regarding our monthly offers and newsletters?

Yes

No

Client Signature: _____

Date: _____

Therapist Signature: _____

Date: _____