



Date

Microneedling Intake Form

Personal Information

Name

DOB

AGE

Address

Phone

Occupation

Email

Are you pregnant or lactating? _____ Yes _____ No

Do you wear contact lenses? _____ Yes _____ No

Do you have any permanent makeup? Please list: _____

Do you currently have a sunburn, windburn, acne flareup or other skin irritation? _____ Yes _____ No

Do you use hair removal products or receive hair removal treatments (depilatories, sugaring, waxing, laser hair removal)? _____ Yes _____ No

Do you currently or regularly use ORAL or TOPICAL medications (Retin-A, Renova, Differin, Tazorac, Benzoyl Peroxide, or Other)? If yes, please list: _____

Have you ever received a chemical peel? _____ Yes _____ No If yes, when? _____

Have you had any type of resurfacing or other procedure using a medical device on your face? _____ Yes _____ No

Do you receive Botox, Filler or Other? _____ Yes _____ No Please list: _____

Do you smoke or vape? _____ Yes _____ No

Do you develop cold sores or fever blisters? _____ Yes _____ No

Do you have any allergies or sensitivities to products? _____ Yes _____ No

By signing below, you agree to the following:

I have completed this form to the best of my ability and knowledge and agree to inform my esthetician of any changes to the information listed on all the pages of this client intake form. I have been informed of and understand the contraindications to the requested treatments and agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform my esthetician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liabilities toward my esthetician and "NAME/COMPANY NAME HERE" for any injury or damages incurred due to my misrepresentation of my health history.

Signature

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Do you smoke or vape? _____Yes _____No

Do you develop cold sores or fever blisters? _____Yes _____No

Do you have any allergies or sensitivities to products? _____Yes _____No

By signing below, you agree to the following:

I have completed this form to the best of my ability and knowledge and agree to inform my esthetician of any changes to the information listed on all the pages of this client intake form. I have been informed of and understand the contraindications to the requested treatments and agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform my esthetician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liabilities toward my esthetician and "NAME/COMPANY NAME HERE" for any injury or damages incurred due to my misrepresentation of my health history.

Signature

Date



Date

Microneedling Consent Form

Personal Information

Name

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1. _____ I agree that I am over the age of 18, am NOT under the influence of alcohol or drugs, am NOT pregnant or nursing and desire to receive the microneedling procedure.
2. _____ I have been informed of the nature, risks, and possible complications and consequences of microneedling. I understand the microneedling procedure may have known or unknown complications including but not limited to: infection, scarring, inconsistent color, or other complications described to me during my consultation.
3. _____ I give permission to "INSERT COMPANY NAME HERE/ESTHETICIAN NAME HERE" to perform the microneedling treatment on me.
4. _____ I understand that there is no guarantee to me as to the condition of my skin or degree of improvement expected following treatment.
5. _____ I understand that multiple treatments and the use of the recommended home skin care maintenance are required to achieve optimal results.
6. _____ I have received pre- and post care instructions and I will strictly adhere to such instructions. I understand that my failure to properly follow pre and post care instructions may compromise my procedure.
7. _____ I understand this procedure may be uncomfortable or slightly painful while being performed.
8. _____ I understand this treatment can not be performed if I have any of the following: infection, skin disorder, open cuts or wounds, abrasions, anxiety issues, epilepsy, pregnant, sunburn, windburn, chapped skin, diabetes, or an active fever blister outbreak.
9. _____ I understand I may experience the following side effects: Fever blisters, white dots (retention cysts), and scabbing.
10. _____ I agree that I have not used Accutane during the last 6 months.

I (print name)

consent to allow "NAME/COMPANY NAME HERE"

to consult with and evaluate me in order to determine if I am a good candidate for microneedling. I understand that photographs and measurements will be taken and kept in my file. I agree that these forms have been completed truthfully and to the best of my knowledge and abilities. I understand the contraindications and possible side effects of microneedling as discussed with "NAME/COMPANY NAME HERE". Furthermore, I agree to waive all liabilities toward "NAME/COMPANY NAME HERE" for any injury or damages incurred due to my misrepresentation of my health history.

Signature

Date



Date

Microneedling Post-Care Instructions

1. Your recovery time will vary depending on the depth and exact procedure performed today. You can expect recovery in 2-4 days or otherwise specified by your skin care specialist/esthetician.
2. Avoid direct sun exposure for 3-5 days.
3. Physical Sunscreen is mandatory. Use an spf 30+ and apply every 2 hours.
4. Refrain from seeking waxing or laser treatments for at least 2 weeks.
5. Avoid exercise, swimming, hot tubs, saunas, and steam rooms for 24 hours.
6. Do NOT exfoliate or use exfoliating products such as Vitamin C, Retin-A, Astringents, Acids, or products containing alcohol or fragrance for 72 hours unless instructed by your skin care specialist/esthetician.
7. Avoid make up for 24 hours.
8. Increase water intake to include at least 8 glasses of water per day.
9. Wash treated area with a gentle cleanser every day for at least 3 days post-procedure. DO NOT USE WASHCLOTH.
10. Do NOT pick at skin, blisters, or scabs.

Additional Instructions or Notes:
