



# MICRONEEDLING

*consultation form*

## CLIENT INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Female / Male / NB \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Your occupation: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

## MEDICAL HISTORY — PLEASE SELECT ANY THAT APPLY

|  |  |  |
|--|--|--|
| <input type="checkbox"/> Active acne           | <input type="checkbox"/> Eczema              | <input type="checkbox"/> Psoriasis             |
| <input type="checkbox"/> Active skin infection | <input type="checkbox"/> Hormonal therapy    | <input type="checkbox"/> Raised lesions        |
| <input type="checkbox"/> Autoimmune disease    | <input type="checkbox"/> Hypersensitive skin | <input type="checkbox"/> Scleroderma           |
| <input type="checkbox"/> Bleeding disorder     | <input type="checkbox"/> Dermatitis          | <input type="checkbox"/> Skin Cancer           |
| <input type="checkbox"/> Cold sores/Herpes     | <input type="checkbox"/> Keloid scarring     | <input type="checkbox"/> Skin disease          |
| <input type="checkbox"/> Cuts or bruises       | <input type="checkbox"/> Pregnant/nursing    | <input type="checkbox"/> Uncontrolled diabetes |

Any other condition: \_\_\_\_\_

Any known allergies? No / Yes: \_\_\_\_\_

List medications/vitamins/supplements you take regularly: \_\_\_\_\_

\_\_\_\_\_



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Are you on any blood thinning medications/supplements (Fish Oil, Ibuprofen, Advil, Motrin)?  Yes  No  
*If yes, please explain:* .....

Have you had chemotherapy/radiation within the last 6 months?  Yes  No  
*If yes, please explain:* .....

Any previous surgeries or cosmetic procedures?  Yes  No  
*If yes, please explain:* .....

Have you had any negative reactions to cosmetic treatments or products before?  Yes  No  
*If yes, please explain:* .....

Are you currently under a doctor's care?  Yes  No  
*If yes, please explain:* .....

## SKIN INFORMATION

Have you had recent sun exposure or tanning?  Yes  No

Do you smoke or use tobacco?  Yes  No

Any recent injectables, chemical peel, microdermabrasion, or laser treatment?  Yes  No

Have you had any facial or dermatology services in the past 30 days?  Yes  No

Do you have permanent or semi-permanent makeup?  Yes  No

In the past six months, have you used any Isotretinoin (Accutane)?  Yes  No

Are you currently using a product containing any of the following:

|   |  |  |
|---|--|--|
| <input type="checkbox"/> Alpha hydroxy acids    | <input type="checkbox"/> Benzoyl Peroxide  | <input type="checkbox"/> Vitamin A derivatives |
| <input type="checkbox"/> Adapalene              | <input type="checkbox"/> Lactic acid       | <input type="checkbox"/> Hydroquinone          |
| <input type="checkbox"/> Any exfoliating scrubs | <input type="checkbox"/> Retinol / Retin-A | <input type="checkbox"/> Other:                |



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## SKIN CONCERNS

- |   |   |                                     |  |
|---|---|-------------------------------------|--|
| <input type="checkbox"/> Acne                 | <input type="checkbox"/> Dark eye circles   | <input type="checkbox"/> Milia      | <input type="checkbox"/> Uneven texture      |
| <input type="checkbox"/> Acne scarring        | <input type="checkbox"/> Dehydrated skin    | <input type="checkbox"/> Oily skin  | <input type="checkbox"/> Uneven tone         |
| <input type="checkbox"/> Age spots/dark spots | <input type="checkbox"/> Dull skin          | <input type="checkbox"/> Redness    | <input type="checkbox"/> Unwanted hair       |
| <input type="checkbox"/> Blackheads           | <input type="checkbox"/> Enlarged pores     | <input type="checkbox"/> Rosacea    | <input type="checkbox"/> Wrinkles/fine lines |
| <input type="checkbox"/> Broken capillaries   | <input type="checkbox"/> Hyper pigmentation | <input type="checkbox"/> Scarring   | <input type="checkbox"/> Other:              |
| <input type="checkbox"/> Clogged pores        | <input type="checkbox"/> Melasma            | <input type="checkbox"/> Sun damage | <input type="checkbox"/>                     |

## THE TREATMENT

Have you previously had microneedling treatments?  Yes  No

*If yes, please explain:* .....

Are you aware of the potential side effects and downtime (redness, swelling, peeling)?  Yes  No

What are your primary goals for microneedling treatment? \_\_\_\_\_

Any questions or concerns about the microneedling procedure? \_\_\_\_\_

By signing below: I have read and completed this questionnaire truthfully. I understand that withholding information or providing inaccurate details about my medical history, allergies, medications, and skincare routines may lead to contraindications or adverse reactions to the treatments I undergo. I agree to inform the technician of any changes in the above information.

\_\_\_\_\_  
*Client Signature*

\_\_\_\_\_  
*Date*