### Client Information

|  |  |
| --- | --- |
| Full Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Birth: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone Number: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email Address: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

### Medical History

|  |  |  |  |
| --- | --- | --- | --- |
| Condition | Yes | No | Comments |
| Pregnancy or breastfeeding | ☐ | ☐ |  |
| Active acne, rosacea, eczema, or psoriasis | ☐ | ☐ |  |
| Allergies (latex, lidocaine, antiseptics) | ☐ | ☐ |  |
| History of keloid scarring | ☐ | ☐ |  |
| Autoimmune diseases (e.g., lupus) | ☐ | ☐ |  |
| Recent use of retinoids (last 7 days) | ☐ | ☐ |  |
| Blood-thinning medications (e.g., aspirin) | ☐ | ☐ |  |
| Recent facial treatments (e.g., laser, peels) | ☐ | ☐ |  |
| Herpes simplex (cold sores) | ☐ | ☐ |  |
| Diabetes or slow healing | ☐ | ☐ |  |
| Skin cancer or precancerous lesions | ☐ | ☐ |  |

### Skin Concerns

What are your primary skin concerns? (Tick all that apply)

|  |  |
| --- | --- |
| Fine lines and wrinkles | ☐ |
| Acne scars | ☐ |
| Uneven skin tone | ☐ |
| Hyperpigmentation | ☐ |
| Enlarged pores | ☐ |
| Dullness or texture irregularities | ☐ |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ☐ |
| Comments: |  |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

### Treatment Goals

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
| Face | ☐ |
| Neck | ☐ |
| Décolletage | ☐ |
| Other (specify): | ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

### Pre-Treatment Checklist

|  |  |  |  |
| --- | --- | --- | --- |
| Requirement | Yes | No | Comments |
| No retinoids, exfoliants, or acids in the past 48 hours | ☐ | ☐ |  |
| No sun exposure or tanning in the past week | ☐ | ☐ |  |
| No alcohol or blood-thinning medications in the past 48 hours | ☐ | ☐ |  |
| Skin is clean and makeup-free | ☐ | ☐ |  |

Do you understand and agree to the above requirements?

☐ Yes ☐ No

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Consent

|  |  |  |
| --- | --- | --- |
| Consent Statement | Yes | No |
| I confirm that I have provided an accurate medical history and understand the importance of disclosing relevant conditions. | ☐ | ☐ |
| I understand that microneedling involves puncturing the skin with tiny needles to promote skin rejuvenation and that there may be temporary redness, swelling, or discomfort. | ☐ | ☐ |
| I am aware that results may vary depending on individual factors and that multiple treatments may be necessary to achieve optimal results. | ☐ | ☐ |
| I have been advised of potential side effects, including temporary dryness, minor bruising, or post-inflammatory hyperpigmentation (rare). | ☐ | ☐ |
| I consent to photographs being taken for medical records (☐ Yes / ☐ No) and/or marketing purposes (☐ Yes / ☐ No). | ☐ | ☐ |
| I confirm that I have received pre- and post-treatment instructions and will follow them. | ☐ | ☐ |

### Signatures

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
| Client Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Practitioner Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

### Post-Treatment Instructions

• Avoid touching the treated area for 24 hours.
• Use only gentle, hydrating products for 48 hours (no active ingredients).
• Apply SPF 30+ daily and avoid sun exposure for 7 days.
• Avoid excessive sweating, swimming, or saunas for 48 hours.
• Follow all aftercare instructions provided by the practitioner.