Patient Information – Microneedling

Name: _____ Date of Birth: ____/____/_____
Occupation: _____ Phone: _____
Email: _____
How did you find us? _____

Do not treat your skin with microneedling if you have the following:

- sunburn
- diabetes
- keloid scarring
- pregnant
- acute cold/flu
- uncontrolled high blood pressure
- prior/current Accutane user
- signs of active infection
- impaired skin
- eczema or dermatitis sufferers
- very dark or unstable skin type
- 1, 2, or 3 on the Fitzpatrick scale
- autoimmune problems, such as Lupus, HIV positive or AIDS
- Cancer
- Hepatitis
- if you have had a topical treatment (such as peels or laser) in the last 12 weeks

What is your daily skin care routine? _____
What is your primary concern? _____

Please circle all that apply:
Hyperpigmentation
Wrinkles
Crows Feet
Nasal Labial Groove
Double Chin
Sagging/drooping, where: _____
Acne/Breakouts
Hair Loss
Scarring
Couperose/ Rosacea
Uneven skin tone
Enlarged Pores
Dry Skin
Oily Skin
Other: _____

Resurfacing treatments in last month? What type? _____
Botox treatments, When? _____
Plastic Surgery, What Kind/When: _____
Use of Retinol/Accutane/Glycolic in last month? _____
High blood pressure, Is it under control of a doctor? _____
Frequent Migraines, how often? Last occurrence? _____
Have you had a professional facial before? If so, when was the last session? _____
Do you form thick or raised scars from cuts or burns? Yes/No
Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Yes/No If yes, which one? _____
Please circle if you have ever had an allergic reaction to any of the following?
Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs
Please explain: _____
_____
Have you been exposed to the sun or used a tanning bed in the last 48 hours? Yes/No

In case of an emergency, whom should we call? Name: _____
Relationship: _____ Phone: _____

For the best results a series is recommended, followed by seasonal maintenance treatments. Understand that results vary depending on health history, lifestyle, age and commitment to the frequency of treatments, skin care regime.

I give consent to undergo microneedling treatments provided by Alora Health Spa. I understand and I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindication and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform my skin care professional of my current medical or health conditions and to update this history. I understand that while microneedling are generally safe methods of treatment, certain adverse effects may result from treatment. With microneedling there may be redness, discomfort and/or swelling, or the sensation of having a sunburn at the area of treatment for 2-3 hours after treatment. Additionally, redness may be present for 2-3 days after treatment. Loss of pigmented lesions such as freckles may give the appearance of loss of pigment. Small areas of scabbing may occur 2-3 days following the treatment. Infection is possible if proper aftercare guidelines are not followed. The treatments I receive here are voluntary and I release Alora Health Spa and/or the skin care professional from liability and assume responsibility thereof.

Signature: _____ Date: _____

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Notes:_____