Dermabrasion - Micro-Needling - Dermaplaning

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Sex: \_\_\_\_\_

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

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

 Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Parent/Guardian(if Client under 18 years of age)  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 **About you:**

 • What is your hereditary background? (circle all that apply) Nordic / Scandinavian / Irish / English / Asian / Mediterranean / Hispanic / Native American / Middle Eastern / African American / Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 • Natural eye color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 • Natural hair color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 • Do you consider your skin (circle the best option): Sensitive / Resilient / Unsure

• Describe your skin (circle all the apply): Normal / Dry / T-Zone/Combination / Thick / Thin / Saggy / Firm / Oily / Acne / Comedones/Blackheads / Milia / Cysts / Breakouts / Acne-scarred / Large pores / Small pores / Rosacea / Eczema / Freckled / Sun-damaged / Melasma / Hyperpigmentation / Hypopigmentation / Uneven/Blotchy / Mature / Wrinkled / Patchy dryness / Sallow / Psoriasis / Dehydrated/Lacking moisture / Asphyxiated / Telangiectasia/Broken surface capillaries

 • What are the changes you would most like to see in your skin?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle:**

• Are you pregnant or lactating? □ No □ Yes (**Please consult with your obstetrician.** Only the **Oxygenating Trio ®**, **Detox Gel Deep Pore Treatment** or **Hydrate: Therapeutic Oat Milk Mask** are appropriate.)

 • Do you wear contact lenses? □ No □ Yes (**Remove contacts** if eyes are sensitive or if having microdermabrasion.)

 • Do you currently have a sunburned/windburned/red face? □ No □ Yes Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 • Are you in the habit of going to tanning booths? □ No □ Yes (If within past 7 days, decline treatment. This practice should be discontinued due to increased risk of skin cancer and signs of aging.)

 • Do you participate in vigorous aerobic activity or sports? □ No □ Yes What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 • Do you smoke or use tobacco? □ No □ Yes

 • What kind of work do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 • On average, how many hours per week do you spend outdoors? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Medical/treatment history:**

 • Do you currently use depilatories or wax? □ No □ Yes (Discontinue use five days pre- and post-treatment.)

 • Have you had a chemical peel, needling treatment or any type of procedure with a medical device? □ No □ Yes

 Within the last 14 days? □ No □ Yes What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 • Do you have regular collagen, Botox® or other dermal filler injections? □ No □ Yes (Peels should precede or follow injections by two days to prevent movement of the filler or stinging at the injection site.)

 • Have you recently had laser resurfacing or facial surgery? □ No □ Yes

 Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 • Are you currently taking any vitamins or medications, topical or otherwise? □ No □ Yes

 **(Discontinue Retin-A,Retinols, & Vitamin A 3-5 days prior / photosensitive medications 72 hours prior / YOU MAY NOT BE ON BLOOD THINNERS while receiving treatment)**

 Which one(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What strength? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (High percentages of certain ingredients may increase sensitivity. Discontinue use 3-5 five days before and after treatment. Consult your physician before discontinuing use of any prescription.)

 • Have you ever undergone Accutane® therapy (isotretinoin)? □ No □ Yes

 (**If you are currently using Accutane® therapy (isotretinoin), please consult with your dispensing physician.**) (If you are no longer using Accutane® therapy (isotretinoin) it is OK to apply ONE layer of **Ultra Peel® I**, **Sensi Peel®**, **Ultra Peel® II**, **Esthetique Peel**, **Oxygenating Trio®**, **Hydrate: Therapeutic Oat Milk Mask** or **Revitalize: Therapeutic Papaya Mask**.)

 • Do you develop cold sores/fever blisters? □ No □ Yes If Yes when was the last breakout? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 • Do you develop keloid scaring? □ No □ Yes

• Do you have any allergies? □ No □ Yes If so, what are you allergic to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Have you ever used any other products that caused a bad reaction? □ No □ Yes

 Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_have been fully informed of the before care preparations for a nano-needling or micro-needling and the risks including but not limited to changes in skin color, infection, scarring, blistering, bleeding, bruising, swelling, and any allergic reaction. Having been informed of the potential risks associated with getting a nano-needling/micro-needling, I wish to proceed with needling, and I assume all risks that may arise from the needling treatment.**

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent or Guardian if under 18: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Clinician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_