MICRONEEDLING
CONSULTATION FORM

Name: ______________________________ Email: ______________________________

Date of Birth: ______________________________ Phone: ______________________________

Consult Date: ______________________________ Physician Name: ______________________________

Aesthetician Name: ______________________________

Please list any allergies: ____

____

What is the reason for your visit today? ____

____

Treatment & Medical History

What is your Treatment History? (Check & Date)

- ☐ Neuromodulator ________________
- ☐ Filler ________________
- ☐ Botox ________________
- ☐ Microdermabrasion ________________
- ☐ Chemical Peel ________________
- ☐ IPL ________________
- ☐ Fraxel ________________
- ☐ Laser ________________
- ☐ Radiofrequency ________________
- ☐ LED ________________
- ☐ Ionto/Sonophoresis ________________
- ☐ Microcurrent ________________
- ☐ Microneedling: ____mm ____Treatments ________
- ☐ Permanent Makeup ________________
- ☐ Microblading ________________
- ☐ Dermaplaning ________________
- ☐ Threading ________________
- ☐ Waxing ________________
- ☐ Other ______________________________

____

What medications are you currently taking?

- ☐ Antibiotics
- ☐ Steroids
- ☐ Anti-histamines
- ☐ Antidepressants
- ☐ Diuretics
- ☐ Anti-Hypertensives
- ☐ Anti-inflammatories
- ☐ Acne Medications
- ☐ Accutane
- ☐ Blood Thinners

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Please list any other medications: ____

____

Please list any vitamins, supplements or dietary supplements you are currently taking: ______________

____

Do you have a history of:

Diabetes? ☐ Yes ☐ No
Thyroid disease? ☐ Yes ☐ No
Endometriosis? ☐ Yes ☐ No
PCOS? ☐ Yes ☐ No
Bowel Disease? ☐ Celiac ☐ Crohn's ☐ Ulcerative Colitis
Skin Disorders? ☐ Eczema ☐ Psoriasis ☐ Dermatitis ☐ Shingles ☐ Cold Sores
Immune Disorders? ☐ Lupus ☐ Rheumatoid ☐ Vitiligo ☐ Thyroid
Other ____

How would you rate your menstrual cycle?

☐ Regular ☐ Irregular ☐ Heavy ☐ Menopausal

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Have you been diagnosed with any medical concerns? ______________________________

____

Family Medical History:

Skin Cancer History ☐ Active ☐ Inactive ☐ None
If applicable, was there removal? ☐ Yes ☐ No

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Family Heritage:

Redhead Gene? ☐ Yes ☐ No

Do you use sun beds? ☐ Yes ☐ No

Tanning ability ______________________________

Where you grew up/live currently ______________________________

Sunburn History ______________________________

Lifestyle Information

Do you smoke? ☐ Yes ☐ No Frequency: __________ / day ________ / yrs ago

Do you drink alcohol? ☐ Yes ☐ No Frequency: __________ / day ________ / yrs ago

Do you drink caffeine? ☐ Yes ☐ No Frequency: __________ / cups per day

Do you use any recreational drugs? ☐ Yes ☐ No

Water Intake: __________ / oz per day

How would you rate your diet?

☐ Extremely Healthy ☐ Generally Healthy ☐ Needs Improvement

Describe your diet:

Breakfast ______________________________

Lunch ______________________________

Dinner ______________________________

How many times per week do you exercise? ______________________________

Current Home Treatments

Cleanser ______________________________

Toner ______________________________

Eye ______________________________

Day ______________________________

Night ______________________________

Sunscreen ______________________________

Enzyme Peel ______________________________

Home Roller ________ mm ______________________________

Make-up ______________________________

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MICRONEEDLING
CONSULTATION FORM

Contraindications

Please check all that apply.

- ☐ Allergies/Medications
- ☐ Blood Pressure/Medication
- ☐ Blood thinning Medication
- ☐ Bleeding Disorders
- ☐ Diabetes Type & Medication
- ☐ Metabolic/ Lymphatic Disorders
- ☐ Osteoporosis
- ☐ PCOS
- ☐ Psoriasis/Medications
- ☐ Eczema/Medications
- ☐ Hepatitis
- ☐ HIV
- ☐ Herpes/Medications
- ☐ Lupus
- ☐ Vitiligo
- ☐ Immune System DIsorders
- ☐ Arthritis/Medications
- ☐ Antidepressant Medication
- ☐ Epilepsy
- ☐ Surgery(Cosmetic)
- ☐ Keloid Scarring
- ☐ Vitamin C supplements
- ☐ Alcohol
- ☐ Major Illness
- ☐ Heart Condition/Medication
- ☐ Bruise Easily
- ☐ Anemia
- ☐ Thyroid Disorders/Medications
- ☐ Poor Absorption of nutrients
- ☐ Oral Contraceptives/HRT
- ☐ Endometriosis
- ☐ Dermatitis/Medication
- ☐ Rosacea/Medication
- ☐ Acne Medication/Roaccutane
- ☐ Fungal Infections/Medication
- ☐ Steroid therapies
- ☐ Pain/Medication
- ☐ Surgery(Medical)
- ☐ Implants
- ☐ OMega 3 or 6 supplements
- ☐ Vitamin D supplements
- ☐ Smoker

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MICRONEEDLING
CONSULTATION FORM

Consent for Procedure

I, ____, authorize and consent to Aqua Spa Aesthetician to perform the following special procedure tor treatment:

Microneedling for the treatment of ____

Description of Procedure

Microneedling allows for controlled induction of the skin's self-repair mechanism by creating micro injuries in the skin to trigger new collagen synthesis. Skin needling treatments are performed in a safe and precise manner with the Sterile needle device and needle head and are normally completed within 30-60 minutes, depending on selected area.

Side Effects

After the procedure there are probable side effects including, but not limited to a red and flushed appearance, similar to a moderate sunburn. Skin tightness and mild sensitivity may also be experienced. These side effects will diminish significantly over the next 24 hours. After 3 days, there will be little evidence that the procedure has taken place.

I have been informed by The Aqua Spa Aesthetician and understand the following:

1. The effect, nature, purpose and gravity of special procedure or treatment;
2. The probable discomforts, material, and probable risks, possible risks with grave consequences, special and unusual risks, potential side effects and complications of the special procedures or treatment and that it is impossible to identify every potential complication; These may include bruising, rash, secondary infection, triggering of HSV (Cold sores), pustules, acne, hyperpigmentation, granulomas, nerve damage, and scarring;
3. The advantages, disadvantages, risks and probable complication of alternative procedures or of receiving no treatment;
4. The reasonable benefits obtainable by the special procedure or treatment and the likelihood of success; but acknowledge that no representations, warranties, guarantees nor assurances can or have been given as to the result that may be obtained.

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MICRONEEDLING
CONSULTATION FORM

Consent For Procedure *(continued)*

I also authorize and consent to:

- Such additional and alternative special procedures or treatments which may be found to be immediately necessary in the professional judgment of the licensed aesthetician present during the performance of the procedure.
- The Aqua Spa Aesthetician has answered all my questions concerning the proposed special procedures or treatment to my satisfaction.
- I agree to pay any charges for the above treatment.

I certify that I have read and fully understand this Consent Procedure Form, the explanations referred to were in fact made to me and the form was filled in prior to commencement of the course treatment. I understand that I am free to withdraw this consent at any time.

____ Date: ______________________

(Signature of Client)

To be completed by Aqua Spa Aesthetician:

I, ____, REVIEWED AND EXPLAINED TO THE PATIENT WHO IN MY OPINION APPEARED TO UNDERSTAND THE NATURE AND CONSEQUENCES OF THE SPECIAL PROCEDURE OR TREATMENT AND AFFIXED HIS/HER SIGNATURE. AN OFFER TO ANSWER ANY QUESTIONS WAS MADE.

____ Date: ______________________

(Signature of Aesthetician)

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MICRONEEDLING
CONSULTATION FORM

Authorization to Obtain and Market Images

Please choose one of the options below and sign the chosen consent.

Option 1:

Photo Consent: Photos will be obtained for records and documentation purposes only.

____ Date: _______________________
(Signature of Client)

Option 2:

Marketing and Educational Photo Consent: Photos will be obtained for records and documentations purposes. Photos will also be used for education and social media/platform sharing purposes. All identifying marks will be cropped or removed, unless treatment is done on the face. I hereby grant permission to Aqua Spa Float Center to photograph myself and use the aforementioned images in education and promotional activities without compensation.

____ Date: _______________________
(Signature of Client)

Option 3:

I do not consent to any photography. I understand that I may not be able to see my results accurately without proper documentation.

____ Date: _______________________
(Signature of Client)

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MICRONEEDLING
TREATMENT LOG

Client Treatment Log

Name: ______________________________ Age: __________ Gender: __________

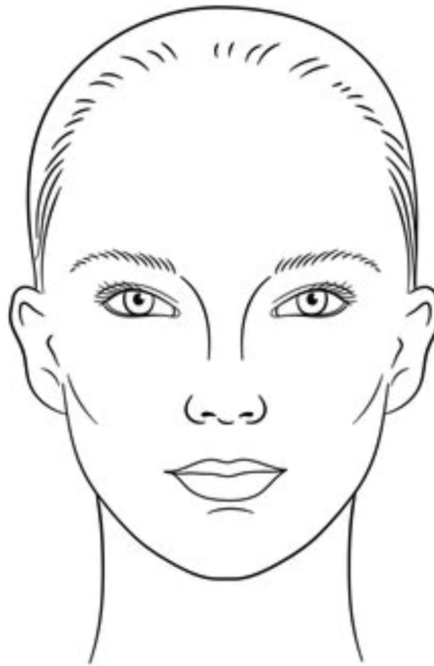
Approved Treatment Protocol: ______________________________

Practitioner Name (Print) ______________________________

Practitioner Signature ______________________________

Treatment Consent Forms signed? ☐ Yes ☐ No

Mark any areas of concern:



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MICRONEEDLING
TREATMENT LOG

Skin Analysis

Fitz. Scale	Skin Type	Sensitive	Thin or Thick Skin	Scarring	Tone
Pigmentation	Fine lines	Wrinkles	Raised skin, moles, lesion, blemishes, concerns	Signs of Trauma	Degree of damage

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MICRONEEDLING
TREATMENT LOG

Treatments

Face

Dates									
Area	Depth	Depth	Depth	Depth	Depth	Depth	Depth	Depth	Depth
Cheeks									
Periorbital									
Crows Feet									
Preorial									
Chin									
Forehead									
Nose									
Neck									

Body

Dates									
Area	Depth	Depth	Depth	Depth	Depth	Depth	Depth	Depth	Depth

MICRONEEDLING
TREATMENT LOG

Appt. Date	Notes

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TREATMENT LOG

Appt. Date	Notes

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