HEALTH at HAND
ADVANCED BODYWORK + ESTHETICS

Microneedling Client Intake Form

General Information

Name | Date of Birth

Address

City | State | Zip Code

Phone # | Email

Occupation

Emergency Contact Name | Phone #

Would you like to be added to our email list for specials and discounts? Yes ☐ No ☐

How did you hear about us?

Medical History

Please check all that apply:

☐ Abrasions	☐ Acne	☐ Aid/HIV
☐ Autoimmune Disorder	☐ Bleeding Disorder	☐ Broken Capillaries
☐ Brow/Lash Tinting	☐ Cancer	☐ Chemical Peel
☐ Cuts	☐ Dermatitis	☐ Diabetes
☐ Eczema	☐ Fever	☐ Hematoma
☐ Hemophilia	☐ Hepatitis	☐ Herpes
☐ History of MSRA	☐ Hypersensitive Skin	☐ Inflammation
☐ Pregnant/Breastfeeding	☐ Radiation/Chemotheraphy	☐ Rosacea
☐ Skin Cancer	☐ Skin Disease	☐ Sunburn
☐ Warts	☐ Other: _____	

Do you have any other allergies? Yes ☐ No ☐

If yes, please list:

Are you currently on any blood-thinning prescription or non-prescription drugs? Yes ☐ No ☐

If yes, what kind?

Are you currently taking any medications? Yes ☐ No ☐

If yes, what kind?

Skin Care History

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

If yes, please explain:

Have you had any of the following surgeries? Please check all that apply:

☐ Blepharoplasty (eyelid surgery)	If yes, when?
☐ Forehead/Brow lift	If yes, when?
☐ Facelift	If yes, when?

Have you used Retin-A, Renova, glycolic acid, AHAs or Retinal products in the last three months? Yes ☐ No ☐

If yes, please explain:

Have you received Botox, Lip Fillers, Restylane, J uvéderm or Collagen injections in the last 6 months? Yes ☐ No ☐

Important Information

What are your main concerns? Please select all that apply:

☐ Acne/Breakouts	☐ Age Spots	☐ Aging
☐ Blackhead/Whiteheads	☐ Broken Capillaries	☐ Cellulite
☐ Clogged Pores	☐ Dark Eye Circles	☐ Dark Spots
☐ Dull/Dry Skin	☐ Enlarged Pores	☐ Excessive Oil/Shine
☐ Hair Loss	☐ Hyperpigmentation	☐ Redness
☐ Rosacea	☐ Scarring	☐ Sun Damage
☐ Uneven Skin Tone	☐ Wrinkles/Fine Lines	☐ Other: _____

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

_____	_____	_____
Name Printed	Signature	Date
_____	_____	_____
Technician Name	Signature	Date

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Microneedling Client Consent and Release

I hereby authorize _____ to perform microneedling therapy (Collagen Induction Therapy).

Please read and initial each of the statements below:

_____ I certify I am over the age of 18.
_____ I understand that this procedure is purely elective.
_____ I understand that this skin treatment involves micro needles that create invisible, vertical micro perforations into the epidermis and the top layer of the dermis, resulting in the natural repair mechanism of the skin to start producing collagen and elastin to repair the microperforations and it may take multiple treatments to achieve desired effects.
_____ I understand that there is a certain level of discomfort associated with the procedure and that each person has their own threshold level for discomfort. Upon consent, my technician may apply topical anesthetics to alleviate discomfort.
_____ I understand there is a small chance of an allergic reaction to topical anesthetics.
_____ I have been informed of the nature, risks, and possible complications, and consequences of microneedling. I understand the microneedling procedure carries with it known and unknown complications and consequences associated with this type of cosmetic procedure, including but not limited to: temporary minor bleeding, bruising of skin surfaces, swelling, redness, irritation, itching, mild burning similar to a sunburn within 72 hours of treatment, temporary and in some cases permanent discoloration such as hyperpigmentation and hypopigmentation, scabbing that can take 7 to 30 days to heal, millia, acne, herpes simplex outbreak (cold sores), infection, and/or scarring.

_____ I certify that I am not under the influence of drugs or alcohol, I am not pregnant or nursing, I have not had recent facial peels or surgery, allergies, skin cancer, uncontrolled diabetes, Lupus, diagnosed keloid scarring, or tendencies to develop cold sores and fever blisters.

_____ I understand there are no guarantees as to the results of this treatment due to many variables, such as age, condition of the skin, sun damage, smoking, drinking, climate, etc.

_____ I understand that my technician only utilizes sterilized, disposable equipment to minimize the risk of infection or contamination and that my technician has received training in appropriate sanitation and hygiene techniques prior to performing any procedures. While the risk of infection from our procedures is extremely small, the possibility of such an occurrence cannot be totally prevented. Accordingly, I understand and accept the risk and release my technician and the spa from any and all liability related to the subject procedure, except instances involving gross negligence.

_____ If I have any signs and symptoms of infections I will seek medical care. Signs of infection include but are not ~~limited to~~ redness, swelling, tenderness of the procedure site, a red streak going from the procedure site towards the heart, elevated temperature, or drainage from the procedure site

_____ I grant permission to _____, to take and use: photographs and/or digital images of ~~me for use~~ in news releases, ~~educational materials and/or soci~~al media platforms including but not limited to Instagram, Facebook, Twitter, Tic Toc, and Pinterest.

_____ If a dispute arises out of or relates to this contract, or the alleged breach thereof, and if the dispute is not ~~settled th~~rough negotiation, the parties agree first to try in good faith to settle the dispute by mediation within 30 days before resorting to arbitration, litigation, or some other dispute resolution procedure.

_____ I have received pre and post-care instructions and I agree to follow them to the best of my ability. I understand that my failure to follow the pre and post care instructions may negatively affect my final result.

By signing below, I agree to the following:

I have read or have had read to me the contents of this whole form. I understand the benefits and risks and alternatives involved in this procedure and I have had the opportunity to ask questions and all of my questions have been answered. I accept full responsibility for the decision to have the microneedling procedure done and understand that there is a no refund policy. I acknowledge that I have reviewed and approved the material given to me.

_____	_____	_____
Name Printed	Signature	Date
_____	_____	_____
Technician Name	Signature	Date

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Microneedling Precare Instructions

Prior to your microneedling session, please observe the following:

- Avoid Accutane 6 months prior to your treatment.
- Avoid IPL/Laser procedures, unprotected sun exposure, or sunburn for at least 2 weeks prior to your treatment.
- Do not receive Botox injections less than 2 weeks prior to treatment.
- Avoid blood-thinning agents for one week prior to your treatment.
- No waxing, depilatory creams, or electrolysis to the area being treated 5-7 days prior to your treatment.
- Do not use retinoids, exfoliants, topical antibiotics, or acids 5-7 days prior to your treatment.
- Do not take anti-inflammatory medications such as ibuprofen, Motrin, or Advil for at least 3 days prior to your session.
- If you are prone to cold sores, take an antiviral agent for 2 days prior to and on the day of the treatment.

On the day of your appointment, please observe the following:

- Do not apply makeup or remove it before coming in for your session.
- Do not shave the treatment area the day of your treatment to avoid skin irritation.

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Microneedling Aftercare Instructions

Avoid sun exposure for at least 24 hours. Do not tan or expose yourself to prolonged sunlight for at least two weeks. ALWAYS use sunblock (30 SPF or higher) .

FOR THE NEXT 3 DAYS:

- Keep the treated area clean by washing with freshly washed hands and mild soap (such as Cetaphil) twice a day.
- Do not use a washcloth or sponge to remove soap.
- Do not use acne cleansers, astringents or anti-aging products.
- Dry the area completely after washing by gently blotting with a clean tissue.
- Only wear mineral makeup.
- Sleep on your back with your head elevated to minimize pain and swelling.
- Avoid recreational water activities such as saunas, hot steam showers, and swimming.
- Avoid vigorous activities that will make you sweat.
- Flaking may occur and is natural. Do NOT pick, scratch, or scrub your skin.
- Allow it to flake off naturally.

Allergic Reaction or Infection: It is rare, but there is a chance of allergic reaction or infection At any time you are uncomfortable please visit your physician for further information.

ONCE HEALED:

- Avoid hot steam showers as they can cause dehydrated skin and inflammation/cellular breakdown.
- Once your skin is no longer red, you may resume your regular skincare routine.
- After the 7 days healing period, always use a sunblock to protect from sun damage.