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**Micro-needling Patient Information and Consent Form**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Single: No Yes Married: No Yes, if yes, anniversary date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does your job require that you work outdoors? No Yes

Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Questionnaire:**

Are you suffering from skin disease or other disease? Yes No
If yes, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under dermatological treatment? Yes No

If yes, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you suffering from skin cancer or actinic keratosis in the areas that should be treated? Yes No

Are you suffering from acne scars? Yes No

Are you suffering from warts or Herpes Simplex Virus? Yes No

Are you developing hyperpigmentation after infections of the skin? Yes No

Are you going through Radiation or Chemotherapy treatment at the moment? Yes No

Are you suffering from uncontrolled Diabetes Mellitus (would healing disorder) Yes No

Are you under drug medication? Yes No

If yes, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you ingesting hormonal drugs? Yes No

Are you ingesting cortisone? Yes No

Are you ingesting anticoagulant drugs (Aspirin, Marcumar)? Yes No

Have you had laser treatment, microdermabrasion, or facial treatments with fruit acid?Yes No

If yes, please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had filler treatment? Yes No

If yes, please specify substance and date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you using Vitamin A Acid or are you ingesting isotretinoin? Yes No

Are you suffering from allergies? Yes No

Are you tending to Keloid formation or are there family members who tend to? Yes No

Are you protecting your skin regularly from the sun? Yes No

Are you pregnant? Yes No

Smoking can cause intense contraindications of the vessels which can lead to a decreased building of petechiae. Therefore; it would be best to avoid smoking at least 3 hours before treatment.

**Clarification and Informed Consent**

Please initial:

\_\_\_\_\_I understand that the fine needles induce the production of new body’s own collagen. There; the needles penetrate the epidermis (top layer of the skin) and cause micro injuries. Due to the wound healing process a lot of different healing factors are released in the skin. This leads to formation of collagen and elastin fibers under the skin surface. This process will take place during 12-16 weeks after the treatment. For an optional result more than one treatment can necessary.

­­­­\_\_\_\_\_I understand that the treatment can have the following side effects:

**Redness and swelling:** During the first das after the treatment redness and swelling can occur. This is because the needle penetration does force micro lesions which will disappear during the healing process. The wounds will be closed very quickly and about 3 hours after the treatment an appropriate makeup can be used.

**Keloid:** If you have the tendency to form keloid scars, the micro lesions which are caused during the micro-needling can also lead to keloids.

**Hyperpigmentation:** It is very rare, but possible that hyperpigmentation occurs in the treated skin area, e.g. after excessive sun exposure. A sun protection factor of 30+ can prevent this.

**Herpes Simplex Virus:** If you already suffered from herpes simplex, the micro-needling treatment can force it once more. A premedication can prevent this.

\_\_\_\_\_Furthermore, Hematomata (bruises), inflammation, itching, and moderate pain can occur after the treatment.

\_\_\_\_\_I understand that it is important to keep out of the sun after the treatment to avoid hyperpigmentation (also no solarium). If I stay outdoors during sunny weather it is recommended to use sun protection with at least SPF 30+.

\_\_\_\_\_I understand that inflammation of the skin after the treatment happens very seldom but is possible.

\_\_\_\_\_Herewith, I confirm that pictures of the treated area can be taken to document the results. These pictures are owned by Paige Simpson of Timeless Aesthetics Beauty Lounge and she can use them for the purpose of presentations or for advertisement.

\_\_\_\_Herewith, I confirm that I will do my best to follow the directions Paige Simpson before, during, and after the treatment. I understand that it is important to obey the directions and to show up for the follow up appointment to get an optima treatment result.

\_\_\_\_The treatment and the possible side effects have been explained to me and I had the opportunity to get all of my questions answered to my full satisfaction. I understand that the purpose of the treatment is to improve the appearance of the skin. It is possible that the intended improvement will not lead to my expected result and that my expectations will not be reached.

\_\_\_\_With my signature I confirm that my personal data as well as the answers to my medical history are correct and to the best of my knowledge.

\_\_\_\_My clinical history has been discussed and possible contraindications have been precluded. During the last 4-6 months prior to the treatment, I have not gone through dermabrasion, surgery or radiation therapy in the treatment area.

\_\_\_\_I confirm that all my questions have been discussed and that I received profound information about effect treatment method and possible side effects.

Client Name (printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Technician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_