

# Consultation Form: Skin Needling

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| NAME: |
| ADDRESS: |
| TELEPHONE NUMBER: | **EMAIL ADDRESS:** |
| DATE OF BIRTH: | **OCCUPATION:**  |
| EMERGENCY CONTACT: | **DOCTORS NAME/SURGERY:** |

*On completion of this consultation card you must tick the Consent Box in order for the treatment to take place.*

Please read the following information prior to booking an appointment in the salon.

**Consultation Information**: to ensure you are not contraindicated to any treatment.

**Pretreatment Advice**: should be read prior to attending an appointment.

**Aftercare Advice**: to be read following your appointment for best results.

Children under the age of 16 should have consent from a parent or guardian prior to any appointment.

**CONSULTATION**

Skin History

Skin Conditions that may affect your suitability for treatment, extra vigilance required: (Please tick any that apply)

* Psoriasis
* Eczema
* Dermatitis
* Acne
* Hay Fever (just be aware that during hay fever season histamine reaction may increase)
* Bronchitis (
* Asthma
* Sensitive Skin
* Sensitive Eyes (therapist should be careful around the eye area)
* Dandruff
* Herpes, cold sores or fever blisters
* Dry Skin
* Diabetes (be extra vigilant as diabetes can cause a lack of skin sensation)

Are you presently using or taking prescription drugs for a skin condition eg. Accutane, Tazorac, Retin-A, Antibiotics or Corticosteroids etc? Please state yes or no. If yes please list details.

Have you taken any of these drugs for a skin condition in the past? Please state yes or no. If yes please list details. (Determine if medication taken has caused (sensitized or changed) as a result of medication. Wash out period of 1 year is required for drugs such as Accutane before having treatment).

Do you have any other skin conditions not listed above? Please state yes or no. If yes please list details. (Note any skin challenges past or present).

**Precautions**

Are you allergic to, or have you ever had any adverse reactions to any medication? Please state yes or no. If yes please list details.

Are you allergic to, or have you ever had any adverse reactions to cosmetics, foods, clothing, soap, shampoo, hair dye, perfumes or jewelry? Please state yes or no. If yes please list details.

Are you currently taking any medication? Please state yes or no.

If yes please list details.

Have you had any medical / health problems in the last 12 months? Please state yes or no. If yes please list details.

Are you pregnant or planning a pregnancy? Please state yes or no.

**Lifestyle**

Have you recently been on holiday where your skin has faced a dramatic climatic change? (sun, snow, wind etc.) Please state yes or no. If yes please list type of change.

Have you recently had any change in your diet, life style or beauty regime? Please state yes or no. If yes please list details.

Have you used active skincare products in the past, or are you presently using active skincare products such as Alpha Hydroxy Acids or Retinol? Please state yes or no. If yes please list details.

Are you suffering from extreme stress? Stress can instantly change the condition. Diet and lifestyles are also huge factors.

**Treatment Considerations**

Skin Needling contra-indications that indicate the treatment should NOT be performed:

(Please tick where appropriate).

* Scleroderma, collagen vascular diseases or cardiac abnormalities
* Active herpes infections
* Rosacea and blood clotting problems (ie poor wound healing)
* Active bacterial, viral or fungal infections
* Taking immunosuppressant medication
* Emotional instability or mental illness
* Pregnant or nursing
* Have had radiation treatment within the last year
* Have areas of the skin that are numb or lack sensation
* Scars that are less than six months old
* Facial surgery in the past 6 months
* Allergy to Medik8 homecare products

Skin Needling recommendations that indicate that skin priming and/or treatment needle length should be adjusted accordingly: (Please tick where appropriate)

* History of keloid or raised scarring
* History of eczema, psoriasis and other chronic conditions
* History of diabetes, use of thinning preparations in the past 6 months
* History of hyper-pigmentation
* Use of isotretinoin (eg Accutane) in the past 6 months

**Notes:**

* Psoriasis and other dermatosis that can be koebnerized, can potentially be triggered by needling even if they have been quiescent for years.
* Since skin becomes thinner with certain topical ingredients, such as corticosteroids and retinoic acid for example, it is recommended that the physician adjusts the microneedle length to compensate for any change in required penetration.
* Patients prone to hyperpigmentation are recommended to use Medik8 White Balance ClickTM4 weeks prior to their treatment appointment.
* Microdermabrasion, laser resurfacing or other facial treatments such as chemical peels, botox, skin fillers, laser skin treatments or plastic surgery should be completely healed.

Skin indications for the treatment: (Needling is suggested for these conditions)

(Please tick where appropriate).

* To increase firmness and tightness to skin
* Fine lines and wrinkles
* To reduce appearance of scar tissue
* Diminish appearance of old surgical scars
* Reduce pigmentation concerns
* Pre-treatment homecare regime:
* Improve overall skin quality
* Reduce pore size
* To help relax old scars
* Improve appearance of cellulite
* To improve appearance of stretch marks

Please confirm that you have been using skincare for two weeks prior to this treatment and list which products you have been using regularly.

**Consent**

Initial consent:

The skin care specialist has explained to me the above indications and contraindications of the treatment to be performed on my skin, which I fully understand. I agree that this series of treatments can be performed by a skincare specialist. I understand that a mild redness and/or irritation may occur. This is a temporary reaction that will subside. I understand that I must wait 24 hours after each treatment (or longer until redness and/or irritation has completely subsided) before resuming the use of home care products that contact AHAs, BHAs or Vitamin A. I understand that to obtain maximum results from the skin needling procedure I must have a series of treatments and use in conjunction with a home care program. I understand that due to the variable nature of the human skin, no guarantee can be made to me regarding the results of this treatment.

CLIENT’S SIGNATURE.......................................................................................................

PRINT NAME..................................................................................................................

THERAPIST’S SIGNATURE.......................................................................................................

PLEASE

PRINT NAME..................................................................................................................

Repeat consent:

I have re-read the Consent Form and no skin indications, contra-indications have changed since my last visit. There has been no change to my health.

1st Treatment/Signature/Date .................................................................................................... 2nd Treatment/Signature/Date .................................................................................................... 3rd Treatment/Signature/Date .................................................................................................... 4th Treatment/Signature/Date .................................................................................................... 5th Treatment/Signature/Date .................................................................................................... 6th Treatment/Signature/Date ....................................................................................................

*By ticking the box, you are agreeing to the following terms and conditions.*

*I accept that any treatment I have has been fully explained to me and will be undertaken at my own risk. I have carried out a patch test (where necessary) and I am satisfied with the explanation of the procedure and the aftercare. I have answered the questions regarding my medical history to the best of my knowledge and accept that failure to disclose relevant information may impact treatment results.*

*I agree to contact Sutherlands Hair and Beauty immediately in the event of any adverse effects.*

*I agree to these terms and conditions (Please tick)*