MICRONEEDLING CONSULT

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

Name _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Phone _____ Do you receive texts? Yes/No

Email _____ Marital/Relationship Status _____

Date of Birth _____ Age _____ Gender _____ Height _____ Weight _____

Emergency Contact _____ Phone _____

Primary Physician _____ Phone/Clinic _____

Occupation _____ Employer _____

How did you hear about Blackbird Acupuncture Clinic?

CONCERNS/INTERESTS (Mark all that apply)

O Acne/Blackheads/Whiteheads
O Acne scars
O Rosacea
O Dryness
O Fine lines
O Wrinkles
O Enlarged Pores
O Discoloration
O Loss of skin tone
O Swelling
O Hyperpigmentation/Brown spots/Pregnancy Mask/Melasma
O Broken capillaries/veins
O Other scars (accident/surgical)
O Aging prevention
Other:_____

Which of the following best describes your skin type? (Please circle one type number)

1. Always burns, never tans
2. Rarely burns, always tans
3. Always Burns, Sometimes tans
4. Brown, moderately pigmented skin
5. Sometimes burns, always tans
6. Black Skin

Which of the following best describes your skin type: (please circle one or more type number)

1. Normal
2. Dry
3. Sensitive
4. Oily
5. Combination
6. Other _____ (explain)

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Please Circle yes (Y) or no (N) to the following questions:

Y/N Do you regularly use tanning salons or sun bathe? If yes last date of tanning _____

Y/N Have you had any of the following within the last 14 days: Chemical Peel, Microdermabrasion, or any other procedure with a medical device?

Y/N Do you have regular injections of collagen, Botox, Restylane or others?
If yes, last date of procedure _____

Y/N Have you recently had facial surgery?
Describe: _____ Date _____

Y/N Have you recently had laser resurfacing? If so when:_____

MEDICAL HISTORY

Y/N Are you actively under the care of a Physician? I(f yes, explain: _____

Y/N Are you currently under the care of a Dermatologist? If yes, explain: _____

Y/N Do you have any of the following medical conditions? (Please mark all that apply)

O Cancer	O HIV/AIDS	O Blood Clotting Abnormalities
O Diabetes	O Eczema	O Skin Disease
O Hypertension	O Keloid Scarring	O Skin Lesions
O Hypotension	O Lupus	O Autoimmune Disease (explain)
O Herpes	O Hepatitis	_____
O Cold Sores	O Thyroid Imbalance	O Other (explain)
O Arthritis	O Active Infection	_____
O Psoriasis	O Rosacea	
O Seizure Disorder	O Hormone Imbalance	

Y/N Do you have any other health problems or medical conditions that we should be aware of or that may prevent you from having this procedure done?
Please list:_____

Y/N Have you ever had an allergic reaction to any of the following? (Please circle all that apply and add detail/explanation as needed)
Food/Latex/Aspirin/Lidocaine/Benzocaine/Tetracaine/Hydrocortisone
Other:_____

Reaction experienced: _____

MEDICATIONS

List all oral medications/supplements/vitamins that you're currently taking including birth control, antibiotics, NSAIDs, hormones, steroids, etc.:

_____

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Please mark any skincare medications/topicals you are currently using:

O Retin-A
O Salicylic Acid
O Differin
O Renova
O Avage
O Hydroquinone
O Accutane
O Other topical agents/Active Ingredients _____

SKINCARE

Please describe your daily skincare routine and products you use:
(cleanser, toner, exfoliant, serums, moisturizer, makeup, SPF, etc.)

_____

_____

HISTORY

Y/N Have you ever had Laser Hair Removal on area to be treated?

Y/N Have you used any of the following hair removal methods in the past six weeks?
Shaving/Waxing/Electrolysis/Plucking/Tweezing/Stringing/Threading/Depilatories

Y/N Have you had any recent tanning or sun exposure that changed the color of your skin?

Y/N Do you form thick or raised scars from cuts or burns?

Y/N Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks from physical trauma? If you, describe: _____

Y/N Are you pregnant or trying to become pregnant or breastfeeding? (circle all that apply)

If yes, are you choosing to undergo microneedling despite the contraindication of microneedling whilst pregnant, trying to become pregnant, or breastfeeding? Y/N initial consent: _____

If yes, I understand that blood and other nutrients will be temporarily directed away from the fetus, uterus, breast which could cause complications in my pregnancy/ability to become pregnant/breastfeeding. I understand that this is a risk I alone am choosing to take. Should complications arise in my pregnancy/ability to become pregnant/breastfeeding after my microneedling procedure, I understand that it is of no fault of the practitioner, clinic, or treatment. I understand and accept these terms and responsibilities. Initial: _____

I understand and have fully read and completed this questionnaire truthfully. I agree that this constitutes full disclosure. I certify that the preceding medical personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the Licensed Acupuncturist of my current medical or health conditions and update this history. I release this institution and/or skin care professional from liability and assume full responsibility thereof.

_____

SIGNATURE DATE

_____

NAME (PRINTED)

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www.blackbirdacupuncture.com

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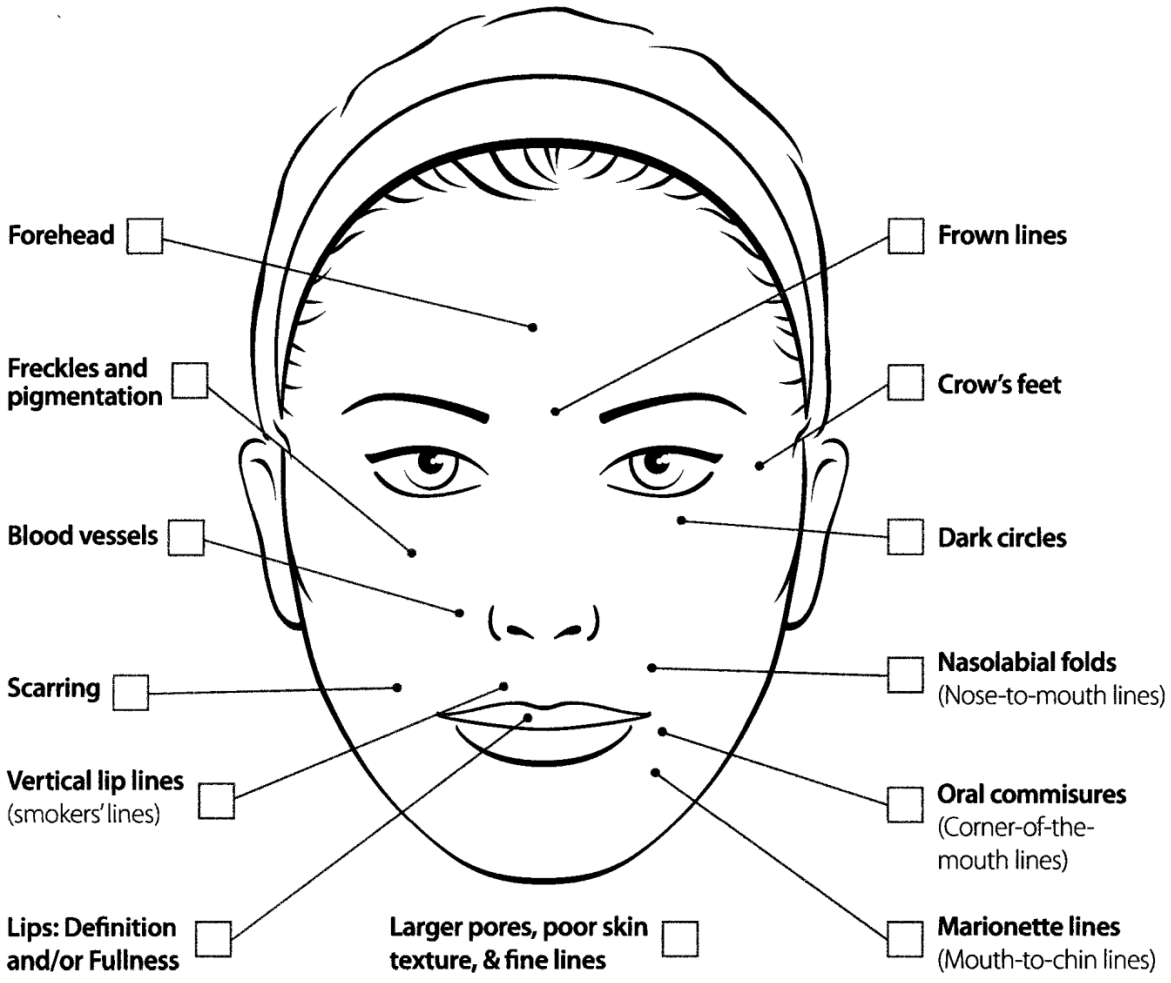
Name: _____

Date: _____

On the diagram below, please indicate areas of concern. You may add your own as needed.



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