



MICRONEEDLING

Consent Form

CLIENT INFORMATION

Full Name: _____ Date of Birth: _____
Phone Number: _____ Email Address: _____
Address: _____

MEDICAL INFORMATION

Do you have any known allergies (e.g., anesthesia, skincare products)? Yes No

If yes, please specify: _____

Are you currently taking any medications (oral or topical), supplements, or over-the-counter drugs?

Yes No

If yes, please list: _____

Do you have any of the following medical conditions?

- Blood clotting disorders
- Active acne or skin infections
- Keloid or hypertrophic scarring
- Immunosuppressive diseases
- Chronic skin conditions (e.g., eczema, psoriasis)
- Recent surgeries, laser treatments, or chemical peels
- Radiation therapy (if yes, please specify: _____)

Are you pregnant, breastfeeding, or trying to become pregnant? Yes No

Have you recently had any cosmetic procedures, including Botox, fillers, or laser treatments?

Yes No

If yes, please specify: _____



TREATMENT INFORMATION

Procedure Description:

Microneedling is a cosmetic treatment in which a device with fine needles creates tiny punctures in the skin, stimulating collagen production and improving skin texture. It is used to treat various skin issues, including fine lines, wrinkles, acne scars, and pigmentation. Depending on the treatment area, the procedure typically lasts between 30-60 minutes.

Expected Results:

Microneedling can improve skin texture, reduce fine lines, scars, and hyperpigmentation over time. Results may vary depending on skin condition and the number of treatments. Multiple sessions may be needed for optimal results, and full results may take several weeks to become visible.

Possible Side Effects:

I understand that Microneedling may cause side effects, including but not limited to:

- Redness, swelling, and discomfort at the treatment site
- Temporary bruising or pinpoint bleeding
- Skin sensitivity, dryness, or peeling
- Hyperpigmentation or darkening of the skin (rare)
- Infection if aftercare instructions are not followed
- Scarring or keloid formation (rare)

Contraindications:

Microneedling is not recommended for individuals who:

- Have active acne, infections, or open wounds in the treatment area
- Have a history of keloid or hypertrophic scarring
- Have recently undergone radiation therapy or have compromised skin
- Are currently pregnant or breastfeeding
- Have a history of autoimmune diseases or chronic skin conditions

CLIENT ACKNOWLEDGMENTS

No Guarantees:

I understand that results from Microneedling treatments may vary. The number of treatments needed for desired results may differ, and the procedure may not be effective for all individuals.

Understanding of Procedure:

I have been informed about the nature of the Microneedling procedure, including the expected results, potential risks, and possible side effects. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.



Post-Treatment Care:

I agree to follow the post-treatment care instructions provided by my practitioner, which include:

- Avoiding direct sunlight and applying sunscreen daily
- Using only recommended skincare products for the first 48 hours
- Refraining from vigorous exercise, saunas, and hot showers for 24-48 hours
- Avoiding makeup for at least 24 hours post-treatment
- Reporting any signs of infection, prolonged redness, or discomfort to my practitioner immediately

Medical History Disclosure:

I confirm that I have provided accurate and complete information about my medical history, including any medications, allergies, and cosmetic procedures. I understand that withholding information may increase the risk of complications.

Pregnancy/Nursing Statement:

I confirm that I am not pregnant, breastfeeding, or trying to become pregnant. I understand that Microneedling is not recommended during pregnancy or while nursing.

PHOTO CONSENT

I consent to have photos taken for the following purposes:

- Personal records
- Educational purposes
- Marketing and social media (identity will be kept confidential)

CONSENT TO TREATMENT:

By signing below, I acknowledge that I have read and fully understood the content of this consent form. I voluntarily consent to undergo the Microneedling procedure, knowing the potential risks, benefits, and alternatives. I also understand that I am responsible for adhering to the post-treatment care instructions provided by my practitioner.

Signature:

Date:

Practitioner Signature:

Date: