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, Juvéderm 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