Pathways To Health Wellness Center
517 S Orange St., Media PA 19063

Microneedling Treatment Intake

This questionnaire provides valuable information which helps us understand the underlying causes of your health concerns. All questions contained in this history form are strictly confidential and will become part of your medical record on file.

PATIENT NAME: _____ **DATE:** _____

SKIN CARE HISTORY

1. Please check any of the following which are of most concern to you:

☐ Bags / swelling under eyes ☐ Vertical creases / furrows ☐ Acne
☐ Sagging face ☐ Premature graying of hair ☐ Acne scarring
☐ Wrinkles ☐ Droopy eyelids ☐ Rosacea
☐ Nasolabial (nose to mouth) ☐ Double chin ☐ Sun damage
☐ Eyes (crow's-feet) ☐ Oily skin ☐ Large pores
☐ Lips ☐ Dry skin ☐ Broken capillaries
☐ Other: _____ ☐ Lusterless skin ☐ Protruding temporal veins
☐ Other skin conditions/issues: _____

2. What improvements to your skin would you like to see?

_____
_____
_____

3. Please describe any skin sensitivities or allergies:

_____
_____
_____

4. Do you wear sunscreen daily? ☐ Yes ☐ No

5. Please describe your current skin care regimen and products that you use. (Toner, astringent, exfoliation, masks, etc.):

_____
_____

6. Do you go to tanning booths? ☐ Yes ☐ No

7. Do you get facial waxing / electrolysis / or use depilatories? ☐ Yes (wait approximately 5 days before treatment) ☐ No

8. Please check all procedures you have had or are currently undergoing.

☐ Botox injections Date(s): _____ ☐ Laser procedures Date(s): _____
☐ Collagen injections Date(s): _____ ☐ Threading (Lift) Date(s): _____
☐ Restylane Date(s): _____ ☐ Rhytidectomy Date(s): _____
☐ Silicone injections Date(s): _____ ☐ Blepharoplasty Date(s): _____
☐ Mesotherapy Date(s): _____ ☐ Brow or Coronal lift Date(s): _____
☐ Accutane Date(s): _____
☐ Microdermabrasion Date(s): _____ ☐ Other: _____ Date(s): _____
☐ Chemical peels Date(s): _____
☐ Microblading Date(s): _____

9. Date of your last menstrual period: _____

Informed Consent for Microneedling Treatment

Introduction

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Microneedling, also called collagen induction therapy, is a minimally invasive technique that uses thin needles, typically 12 micro tips, to create microchannels in the skin. The “wounds” created help stimulate the skin’s own healing process by producing more collagen and elastin to the areas treated. Cellular turnover is also enhanced and the end result is firm, smoother skin, more even skin tone, and the reduction of scars, pore size, wrinkles and stretch marks. In addition to the shifts in appearance, the open channels allow for an increase of up to 2000% of products placed on the skin.

Risks of the Microneedling treatment
Every procedure involves a certain amount of risk and it is important that you understand the risks involved with Microneedling treatment. Although the majority of patients do not experience the following complications, you should discuss each of them with your acupuncturist to make sure you understand the risks, potential complications, and consequences of the **Microneedling** treatment.

- *Bruising*: There is a possibility of bruising (hematoma) from needles.
- *Unsatisfactory Result*: There is the possibility of a poor result from facial rejuvenation acupuncture. You may be disappointed with the results.
- *Allergic Reactions*: In rare cases, local allergies to topical products have been reported. Allergic reactions may require additional treatment.
- *Scarring*: In rare cases, scarring may occur.

Short-Term Side Effects
Post microneedling you may experience the following:

- *Redness*: Your skin may appear red, similar to a mild sunburn and be warm to touch.
- *Dryness*: As part of the healing process, skin may have minor flaking or peel.
- *Hyperpigmentation:* As hyperpigmentation and sun spots are treated, they may appear darker and should resolve with additional treatments.

Contraindications for Microneedling

- Pregnancy however nano needling may be used
- Active contagious diseases (shingles, cold sores, etc.)
- Open wounds, active acne, and warts
- Coagulant or blood thinning therapy
- Cancer patients in treatment
- Accutane within 3 months
- Keloidal fibroma
- Discoid Lupus

Microneedling treatments do not stop the aging process or permanently alter the appearance of the face and neck. Future treatments may be necessary to maintain the results of the **Microneedling** treatment.

Introduction
LED (light-emitting diode) light therapy is **a non-invasive treatment that enters the skin's layers to improve the skin. Effective to use with facial rejuvenation therapies, it is safe and effective.**

Contraindications for LED Light Therapy

- Diseases of the retina
- Photosensitizing medications like lithium, melatonin, phenothiazine antipsychotics and certain antibiotics

Disclaimer
Informed consent documents are used to communicate information about the proposed procedure along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your acupuncturist may provide you with additional or different information which is based upon all the facts in your particular case and the present state of knowledge within the field of acupuncture. Informed consent documents are not intended to define or serve as the standard of acupuncture. Standards of acupuncture are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve. It is important that you read the above information carefully and have all of your questions answered before signing the following consent.

CONSENT FOR Microneedling TREATMENT

1. I hereby authorize licensed acupuncturists and such assistants of Pathways To Health Wellness Center as may be selected to perform facial rejuvenation acupuncture. I have received the INFORMED CONSENT FOR Microneedling TREATMENT.

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2. I recognize that during the course of the **Microneedling Treatment**, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the acupuncturists and assistants or designees of Pathways To Health Wellness Center to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my acupuncturist at the time the procedure is begun.

3. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

4. It has been explained to me in a way that I understand:
   a. The above treatment or exposure to be undertaken
   b. There may be alternative procedures or methods of treatment
   c. There are risks to the procedure or treatment proposed

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-4). I AM SATISFIED WITH THE EXPLANATION.

_____	_____	_____
Patient's Name (Printed)	Patient's Signature	Date