CLIENT HISTORY

Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Home Phone:_____ Business Phone: _____

Cell Phone:_____ May we contact you at these numbers?_____

Email Address: _____Other ID: _____

Referred by: _____

Emergency Contact:_____Phone Number_____

PROCEDURE(S) DESIRED: Circle all of the following that apply.

Upper eyeliner	Partial eyebrows	Lip liner	Beauty mark	Areola Pigmentation
Lower eyeliner	Full eyebrows	Full lip color	Scar Camouflage	Dry Needling

ALLERGIES/SENSITIVITES: Circle if you have ever had a reaction to any of the following and describe below:

Latex/ rubber	Lanolin	PABA	Tattoo ink/pigment
Bacitracin ointment	Metals	Novocaine,	Hydroquinone or other skin bleaching agents
Benzocaine, Tetracaine	Aspirin	Hydrocortisone	Neomycin or polymyxin B ointment
Animal Protein	Lidocaine	Foods	

Other Allergies/Sensitivities_____
Reactions _____

EYES/EYEBROWS: Circle all of the following that apply.

Contact Lenses	Eye makeup sensitivities	Blurred Vision	Alopecia Universalis (total)
Glaucoma	Lasik/eye surgery	Thyroid abnormalities	Alopecia Areata (local)
Dry Eyes	Trichotillomania (pulling out lashes/eyebrows compulsively)		

Eyebrow/Lash tinting
Date of last service: _____

Botox
Date of last service:_____

Other eye disorders (describe)_____
Other hair loss (describe) _____
Are you planning any vision corrective surgery? _____ No procedures can be preformed 1 month prior to vision surgery and 3 months after.

LIPS: Circle all that apply

Cold sores/fever blisters/herpes - if so a prescription is required prior to any lip service
Lip injections – Type _____Date_____
Other lip augmentation _____Date _____
Teeth Bleaching _____Date _____

SKIN: Please use back of form if necessary to answer all questions.

Any other tattoos - Location: _____

If yes, I will need to know if it was between the years 2000 and 2004 that Premier True Concentrates were not used and I will require written documentation from your previous practitioner that this product was not used. The Premier Pigment described can trigger an allergic reaction.

Age of tattoo: _____ Any problems: _____

Use of sunlamp/tanning bed/suntan outdoors _____ Currently tanned in the area being treated._____

Currently use Retin A - Location: _____ Currently using glycolic acids _____

Facial fillers or botox? When?_____ AHA or retinol skin products _____

Do you have any dermatologic disorders such as shingles, rosacia, eczema or psoriasis_____

If they are active they must have calmed down before the procedure.

Have you had any injectables such as Restylane, Juvederm or other fillers? (describe) _____

_____

Ever had a chemical peel? When:_____ Type of peel:_____

Have you ever taken Accutane or any other treatment for acne(describe)_____

Have you ever had any laser treatments, or plan to in the future? (describe)_____

IT IS IMPORTANT TO UNDERSTAND THAT LASER TREATMENTS, IPLs (intense pulse lights) including those used for hair removal, anti-aging, Photo Facials and removal of lines MAY OR WILL TURN PIGMENTS DARK OR EVEN BLACK

Do you have a scar you want camouflaged? Age of Scar: _____

Any keloid (raised white) or hypertrophic scars? - Location: _____

Do you bruise or bleed easily? _____ Do you have healing problems? _____

Any other skin disorders? Describe: _____

GENERAL MEDICAL: **Circle** all of the following that apply.

High Blood Pressure	Diabetes	Hemophilia or other clotting disorder	Chemotherapy
Mitral valve prolapse	Valve implants	Heart palpitations or conditions	Hepatitis
Pregnant or nursing	HIV	Autoimmune disorders	Seizures

Do you currently take any blood thinners or anticoagulants such as aspirin, ibuprofen, Coumadin, Homeopathic, vitamins or herbs, alcohol. Describe_____

If you had or are planning any cosmetic/other surgeries in the future please describe_____

_____

If you are under the care of a physician for any reason please describe _____

_____

Physicians Name_____City_____Phone_____

List any surgeries_____

_____

Please list all medications, prescription and non-prescription. Use back of form if necessary.

_____

_____

_____

I certify that the preceding medical, medication and personal history statements are true and correct. I understand that it is my responsibility to keep my technician informed and update this history.

Signature_____Date_____

INFORMATION FOR MICRONEEDLING

WHAT IS MICRONEEDLING?

MICRONEEDLING is a cosmetic treatment that can be used to blend scars, improve rough and uneven skin texture, reduce fine lines and wrinkles and improve elasticity. It is based on the skin's natural ability to repair itself. By creating controlled injuries in the upper layers of the skin, microneedling stimulates the body to produce new collagen and elastin in the area that is being treated. The result is smoother, firmer, younger looking skin.

A topical anesthetic is applied and a pen-like device with micro needles is used to create tiny channels for the new collagen and elastin to improve the skin's condition.

This repairing or healing process will take about one month for superficial results and the skin will continue to remodel for up to five months. For deeper lines, wrinkles or scars, multiple treatments may be necessary to achieve desired results.

WHAT TO EXPECT

There are two types of needling treatments.

1. Collagen stimulation is a noninvasive treatment that uses microneedles which are brushed over the skin's surface penetrating the upper layers of the skin to stimulate your body to produce collagen and elastin. Your skin will appear red and or blotchy immediately after the treatment. There may be minimal swelling. These reactions usually subside within the first day. If your skin is sensitive, you may experience a few days of this reaction. Clean, new mineral based makeup may be applied after the first day.
2. Scar and or wrinkle reduction requires a smaller group of microneedles that target the specific area, bringing blood to the surface to produce new, healthy skin. The area being treated will be very red and more visible for a few days after treatment. This produces a more dramatic result. The area must be kept clean and moist to avoid infection.

Does it hurt?

A topical anesthetic is applied before and during the treatment to ensure your comfort. Most people describe the sensation as the feeling of an exfoliating cleanser or buffer on the skin in the case of the collagen stimulation treatment. Some areas as in wrinkles will be felt more but the sensation lasts only a matter of seconds in that area.

How much does it cost?

Treatments range from $150 to $1000 depending on your desired level of outcome. Each treatment is customized to fit your needs and discounts are available for multiple areas or appointments. Compared to other treatments such as cosmetic surgery or lasers, the cost is very affordable.

How long will it last?

Your skin will continue to improve for up to 5 months after each treatment and the results on scars etc. can be permanent, however, your skin will continue to age and environmental factors such as sun damage will always be a factor. A good skin care regimen and other preventative measures will ensure that your skin stays as healthy as possible. For some people, one treatment will be enough. For maximum results, 3 or more treatments may be recommended.

MICRONEEDLING QUESTIONS

1. Are you on blood pressure medication, have a heart condition or diabetes?
   _____

2. Have you ever had a fever blister or cold sore? _____

3. Have you ever had any type of facial skin disease or disorder?_____

4. Do you have acne? _____ Is it active? _____

5. Do you have any scars that are less than 6 months old? _____

6. Have you had any fillers or botox within the last 4 months or permanent fillers such as Dermagen or Shark cartilage in the past 6 months? _____

7. Have you had any facial surgery within the last 6 months? _____

8. Have you had any sensitivity to lidocaine, tetracaine or benzocaine? _____

9. Are you using any corto-steroids on the treatment areas? _____

10. Have you had any laser treatments? Describe _____

11. Are you taking any medications such as ibuprofen, aspirin, coumidin, including homeopathic such as fish oil, vitamins or herbs that thin the blood? Describe _____

12. Do you or have you ever had a darkening of the skin(hyperpigmentation) after an injury? _____

13. Do you have any keloid (raised) scars? Where?_____
14. Have you had any moles, warts or lesions in the treatment area?_____
15. Please list all products being used on the skin. _____
    _____

Name _____Procedure_____
Date_____ Signature_____

INFORMED CONSENT TO MICRONEEDLING PROCEDURE

Initial:

1. I absolutely understand and accept that such procedure is an elective procedure, not medically necessary, and is a process, often requiring multiple applications to achieve desirable results. 100% success cannot be guaranteed. I agree to cooperate with Kim Witwer and La'Derma in this process which may involve multiple treatments and periods of healing between treatments ranging from 2 weeks to 3 months depending on how my skin heals. _____

2. I do____ do not_____ have a history of keloids or hypertrophic (raised) scars.

3. I do_____do not_____ have a history of getting dark areas when my skin is injured. (aka hyperpigmentation)

4. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration, swelling and or fever blisters on the lip area following procedures around the lip. _____

5. I have received pre and post-procedure instructions and I will strictly adhere to such instructions. I understand that my failure to do so may jeopardize my chances for a successful procedure. I have disclosed all medications, prescription or non-prescription and their purpose or indications. I have disclosed any medical conditions that may affect the healing of my skin. If I have ever had cold sores (fever blisters, herpes), I will consult with and strictly follow my doctor's instructions before having any procedure around my lips.
_____

6. I understand the procedure carries with it known and unknown complications including but not limited to infection, allergic reaction, no improvement, increased scar formation or hyperpigmentation and agree to proceed. I know that sometimes I may experience redness, tingling, superficial abrasions and temporary scab formation and flaking. I agree to follow the recommended skincare after and between treatments as recommended for my skin problem and type. _____

7. I agree to accompany my practitioner to the emergency room in the event they were to be accidentally stuck with my needle and take a blood test for their safety & disclose all test results to my practitioner. _____

8. I am aware that if an infection occurs after I have received microneedling to see my primary physician or an emergency room, ***immediately***. _____

9. This procedure is being performed under standard sanitizing and sterilizing methods recommended by the Center for Disease Control. La'Derma uses only sterile, one time use needles and disposes of all needles appropriately after use. I verify that the needle(s) being used in my procedure are sterile and witnessed the unopened needle packaging. _____

10. In consideration of Kim Witwer and La'Derma providing me the service requested,I for myself, my spouse, legal representatives, heirs and assigns, hereby release, waive and discharge Kim Witwer (dba La'Derma) from liability for, and all loss or damage on account of, injury to my person. I understand several procedures may be necessary to achieve the desired effect and agree to complete my treatment and payment. Should I not complete treatments, I will be responsible for any adverse outcome. _____

9. I understand that the taking of before and after photographs of the said procedure(s) are a condition of said procedure(s) and give Kim Witwer and La'Derma the permission to use these photographs for client care, information, marketing and presentations. _____

ACCEPTANCE: I am over the age of 18, am not under the influence of drugs or alcohol, am not pregnant or nursing and request the indicated procedure. I give my consent to Kim Witwer and La'Derma for medical information required for the safety of my procedure(s).I have read and understand these risks listed above and they have been explained to me. **I DID NOT JUST SIGN THIS DOCUMENT WITHOUT READING IT.** I certify that the information in the above questionnaire is accurate and my questions have been answered. I accept full responsibility for any complications that may arise or result during or following the cosmetic procedure(s) to be performed at my request.

Signature of Client X_____ Signature of Practitioner_____

Procedure(s)_____Date_____