MicroChanneling Screening Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

How did you hear about us? _____

Yes No Are you over 18 years of age?
Yes No Have you taken aspirin or blood thinners in the past 7 days?
Yes No Do you have an allergy to Aloe Vera?
Yes No Have you taken any mood altering drugs in the past 8 hours?
_____ (initial) I understand that if I have a history of cold sores, herpes or fever blisters I must take my medication prescribed by my physician in advance or tell the technician to skip treatment around my lips.
Signature _____
Yes No Are you sensitive to Latex?
Yes No Have you had a chemical or LASER peel? If so, when? _____
Yes No Do you have trouble healing?
Yes No Have you had any botox or fillers? If so, when? _____
Yes No Are you currently undergoing radiation or chemotherapy?
Yes No Are you currently using Accutane, Retin-A, AHA, or other exfoliating skin care products?
Yes No Are you allergic to any metals? If so, what? _____
Yes No Are you currently taking anti-inflammatory medications or steroids?
Yes No Are you allergic to any anesthetics, (any of the “caines”)? If so, which? _____
Yes No Do you have a history of skin disease?
Yes No Do you have a history of skin sensitivity?
Yes No Are you currently taking vitamin A or E in any form?
Yes No Are you pregnant or nursing?
Yes No Are you currently being treated by a dermatologist? If yes, what for? _____ Derm name: _____

Please circle any that apply to you:

Heart Condition Hepatitis HIV Cold Sores
Hyper Pigment Smoker Keloid Above Neck Allergic to Steel Accutane in last 2 yrs Diabetes (uncontrolled) Chronic Skin Disease Hemophilia

Patient name: _____ Date: _____

I authorize _____ to perform Microchanneling on my skin, and to apply topical preparations as determined necessary.

I understand that Microchanneling is non-ablative skin rejuvenation & involves the creation of perforations in my skin to promote healing responses to rejuvenate my skin. I understand that the procedure is performed with an automatic perforating device and that clinical results may vary. I understand there is a possibility of short-term effects such as reddening, peeling, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as infection & scarring. These effects have been fully explained to me.

Clinical results may vary depending on individual factors, including medical history, amount of sun damage or textural problems, skin type, and my compliance with pre/post treatment instructions.

I understand that the Microchanneling treatment may involve a series of treatments and the fee structure has been fully explained to me.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time. I also have completed a medical history checklist and been informed about what I must do and “not do” before, during and after the procedure.

I understand that the taking of before and after photographs of the said procedure(s) are a condition of such procedure(s). Initial _____

I consent and authorize the use of any photographs of me for the purposes of marketing and education:
Yes _____ No_____ If no, may we blur out your face and/or tattoos and use the photos that way?
Yes _____ No _____

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

I furthermore indemnify the authorized person herein, and hold harmless from any and all claims, demands, liabilities, judgments, costs and expenses arising out of any claims relating to the procedure authorized herein.

Patient Signature: _____ Date: _____