7575 Dr. Phillips Blvd. #155, Orlando, FL 32819
407-574-8383

Skin Needling Medical and Consent

The following confidential medical information will be property of About Face Ink LLC. This is required for the benefit and safety of the client in obtaining any and all procedures performed by About Face Ink LLC. Please read and fill out the information carefully. We hope your experience will be a pleasant one and we thank you for your cooperation:

NAME: ____DOB: ___________________ Age: ______

EMAIL: ____

ADDRESS: ____

____

PHONE : _________________________ Cell / Landline Alt Phone: _________________________ Cell / Landline

Cell phone provider ________________ (So that you can receive reminder text about your appointments).

How did you hear about us? ____

Would you like to be informed of any specials, discounts or events in the future? Yes /No

(If needling around lips) **HAVE YOU EVER HAD A FEVER BLISTER OR COLD SORE?** Yes /No

IF YES, contact your physician for a prescription of ZOVIRAX or some other anti-viral medication.

Initial ______ I have read the above information regarding an anti-viral and understand its use is mandatory, If I desire skin needling in and around the lip area.

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? Yes / No

If Yes Why? ____

PHYSICIAN NAME: ____________________________________Phone Number___________________________________

Are You Pregnant Yes / No

Are you suffering from skin disease or other disease? Yes / No

If yes, please specify: ____

Are you under dermatological treatment? Yes / No

If yes, please specify: ____

Are you suffering from skin cancer in the area/s to be treated? Yes / No

Are you suffering from active acne? Yes / No

Are you suffering from warts or herpes simplex? Yes / No

Do you develop hyper pigmentation? Yes / No

Are you going through radiation or chemotherapy treatment at this moment? Yes / No

Are you suffering from uncontrolled diabetes mellitus (wound healing disorder)? Yes / No

Are you taking any prescribed medications? Yes / No

If yes please specify: ____

Are you taking any recreational drugs? Yes / No

Are you taking any hormonal drugs? Yes / No

Are you taking any oral cortisone/steroids? Yes / No

Are you taking any anticoagulant drugs (Aspirin, Marcumar)? Yes / No

Have you had a laser treatment, microdermabrasion or facial treatments with fruit acid? Yes / No

If yes, please specify the date. ____

Have you had any fillers? Yes / No

If yes, please specify substance and date: ____

Are you using Vitamin A Acid or are you taking isotretinoin? Yes / No

Are you suffering from allergies? Yes / No

Do you tend to form Keloids or are there family members who tend to? Yes / No

If yes, are the Keloids on your joints, hands or feet? Yes / No

Do you protect your skin daily from the sun with sunscreen? Yes / No

The undersigned, (name)____

Hereby declares the following:

I am aware of the fact that in the event of pregnancy, I will be advised against undergoing a skin needling treatment due to increased susceptibility to infections **Yes/No**

I do/do not suffer from any form of the following:

- Hemophilia
- Chronic skin disease
- Contact allergy
- Diabetes
- Immune disorder
- Cardiovascular disorders

If I have answered 'Yes' to any of the above, the skin needling specialist has clearly explained the implications of these disorders on the treatment to which I consent.

Initial _____ I wish to begin a series skin needling treatments on the following area/s___________________________________

____

Initial _____ I understand that the fine needles used during the skin needling treatment, induce the production of the body's own new collagen. The needles penetrate the epidermis (top layer of the skin) and cause micro injuries. Due to the wound healing process a lot of different healing factors are released in the skin. This leads to the formation of collagen and elastin fibres under the skin surface.

Initial _____ I understand that skin needling can have the following side effects: **Redness and swelling:** During the first days after treatment, redness and swelling can occur. This is because the needle penetration does force micro lesions, which dis-appear during the healing process. The wounds will close very quickly and about 24 hours after treatment an appropriate makeup can be used. **Keloid:** If you have the tendency to form keloid scars, the micro lesions, which are caused during the skin needling, can also lead to keloids. **Hyper pigmentation:** It is very rare but possible that hyper pigmentation occurs in the treated area. E.g. after excessive sun exposure. A sun protector of 30+ can prevent this. **Herpes simplex**: If you have suffered from herpes simplex, the skin needling treatment can force it again. A premedication can prevent this. Furthermore bruising, inflammation, itching and moderate pain can occur after the treatment.

Initial _____ I understand that it is important to keep out of the sun after the treatment to avoid hyper pigmentation. If I stay outdoors during sunny weather I MUST use sun protection with at least SPF 30

Initial _____ I understand that skin needling is performed in a series of treatments. Depending on the age of skin and the desired result there will be a minimum of 3-6 treatments needed in approximately 30 day intervals.

Initial _____ The treatment and the possible side effects have been explained to me and I had the opportunity to get all my questions answered to my full satisfaction. I understand that the purpose of the treatment is to improve the appearance of the skin. It is possible that the intended improvement will not lead to my expected result and that my expectations will not be reached.

Initial _____ I confirm that my personal data as well as the answers to my medical history are correct and to the best of my knowledge.

Initial ______ My clinical history has been discussed and possible contra indications have been precluded. During the last 4-6 months prior to the treatment, I have not gone through dermabrasion, surgery or radiation therapy in the treatment area.

Initial______ **I have received post procedure instructions and healing chart and I will adhere to such instructions. I understand that my failure to do so may jeopardize my chances for a successful procedure.**

Initial _____ **I confirm that I will follow the pre and post care instructions. I understand that it is not only important to follow all instructions, but to also show up for all visits as described above to get optimal treatment results.**

Initial _____ I confirm that all my questions have been discussed and that I have been given information about effect, treatment method and possible side effects.

Initial______I hereby authorize About Face Ink LLC to take photographs of the work performed both before and after. I further authorize the use of said photographs to be used to show potential clients as an example of work performed by About Face Ink LLC for the purpose of advertising.

Initial_____I hereby authorize About Face Ink LLC to take photographs of the work performed both before and after treatment to be maintained in file.

Initial______ I am fully aware that all of my procedures will be performed by About Face Ink LLC and it's practitioners. I hereby agree to waive and release to the fullest extent permitted by law About Face Ink LLC and it's practitioners from ALL liability whatsoever, for any and all claims or causes of action that I, my estate, heirs, executors, or assigned may have for personal injury or otherwise, including and direct/and or consequental damages which result or arise from the application of my Permanent Cosmetic tattoo, whether caused by negligance or fault of About Face Ink LLC or it's practitioners.

Initial______ I agree to reimburse About Face Ink LLC and it's practitioners for any attorneys' fees and costs incurred in any legal action I bring against About Face Ink LLC or it's practitoners in which About Face Ink LLC or it practitioners is the prevailing party.

I have reviewed and understand all the information given to me. I understand this is a contract and that I have received no warranties or guarantees with any of my procedures.). I further acknowledge that at the time of signing this consent to this procedure(s), I was of sound mind and capable of making independent decisions for myself.

- I have made an informed decision to undergo skin needling and do so of my own free will.
- I was not under the influence of alcohol or drugs before or during the treatment.
- I do not currently have any discoloration, swelling, bumps or other form of irritation on my body and consider myself healthy enough to undergo this cosmetic treatment.
- I am not currently using any anticoagulants.
- In the event a dermatologist is treating me, I consulted the dermatologist before deciding whether or not to undergo a skin needling treatment.

____ ________________________

Clients Signature Date

Fitzpatrick Skin-Type Chart

You can use this skin-type chart for self-assessment, by adding up the score for each of the questions you've answered. At the end there is a scale providing a range for each of the six skin-type categories. Following the scale is an explanation of each of the skin types. You can quickly and easily determine which skin type you are.

Genetic Disposition

Score	0	1	2	3	4
What is the color of your eyes?	Light Blue, Grey, Green	Blue, Grey or Green	Blue	Dark Brown	Brownish Black
What is the natural color of Your hair?	Sandy Red	Blonde	Chestnut/Dark Blonde	Dark Brown	Black
What is the color of your skin (Non-exposed areas)?	Reddish	Very pale	Pale with beige tint	Light Brown	Dark Brown
Do you have freckles on Un-exposed areas?	Many	Several	Few	Incidental	None

Total score for Genetic Disposition: _____

Reaction to Sun Exposure

Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare Burns	Never had Burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark Brown Quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very	Never had a problem

Total score for Reaction to Sun Exposure: _____

Tanning Habits

Score	0	1	2	3	4
When did you last expose your body to sun (or artificial sunlamp/tanning bed or cream)?	More Than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always

Total score for Tanning Habits: _____

Add up the total for each of the three sections for your Skin Type Score.

Skin Type Score – Fitzpatrick Skin Type

0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V-VI

Type 1: Highly sensitive, always burns, never tans. Example: Red hair with freckles.
Type 2: Very sun sensitive burns easily, tans minimally. Example: Fair skinned, fair-haired Caucasians.
Type 3: Sun sensitive skin, sometimes burns, slowly tans to light brown. Example: Darker Caucasians.
Type 4: Minimally sun sensitive, burns minimally, always tans to moderate brown. Example: Mediterranean type Caucasians, some Hispanics.
Type 5: Sun insensitive skin, rarely burns, tans well. Example: Some Hispanics, some blacks.
Type 6: Sun insensitive, never burns, deeply pigmented, Example: Darker Blacks.

To be filled out by About Face

Please bring with you to your procedure.

Skin Needling Procedure Record

OFFICIAL RECORDS TO BE HELD BY ABOUT FACE INK LLC

Name of client: ____

Date of procedure: ____

Price Charged: ____

Machine: ____ Speed: ____

Needle size: ________________________________ Area Treated: ____

Result: ____

Type of topical: ____

Procedure Performed by: ____

Notes: