Microchanneling Intake

Name: ____ Date of Birth: _______________

Address: ____

____

Home Phone: ______________ Cell: _____________________ circle preferred (H) or (C)

Email: ____

Emergency Contact:: _______________________________ Phone: __________________

Referred By: ____

Are you over 18 years of age?	**Y**	**N**
For women, are you pregnant?	**Y**	**N**
Are you undergoing radiation or chemotherapy?	**Y**	**N**
Are you on any aspirin or blood thinners?	**Y**	**N**
Are you currently taking anti-inflammatory medications or steroids?	**Y**	**N**
Are you currently taking any Vitamin A or E?	**Y**	**N**
Do you have a history of cold sores, herpes or fever blisters? Please explain: ____	**Y**	**N**
Have you had any injectables in the last 30 days? Please explain: ____	**Y**	**N**
Are you sensitive to Latex?	**Y**	**N**
Are you allergic to metals?	**Y**	**N**
Have you had any mood altering drugs in the past 8 hours?	**Y**	**N**
Do you have trouble healing?	**Y**	**N**
Are you currently taking any Vitamin A or E?	**Y**	**N**
Are you using any Retin-A, AHA,or other exfoliating skin care products?	**Y**	**N**
Have you recently had a chemical peel or Laser Treatment?	**Y**	**N**

PLEASE CIRCLE IF YOU HAVE, OR HAVE A HISTORY OF THE FOLLOWING:

Heart Condition **Diabetes** **HIV** **Cold Sores** **Hyperpigment**

Smoker **Compromised Immunity** **Accutane in last 6 months** **Steel Allergy**

Hemophilia **Chronic Skin Disease**

Microchanneling Consent Form

Therapeutic Bodywork has the authorization 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.

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, and that there are no refunds offered for lack of satisfactory results. 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 consent to the taking of photographs and authorize their anonymous use for the purposes of clinical audit, education and promotion.

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.

Signature: ____ Date: ______________

Parental Guardian (if under 18): ___________________________ Date: _______________