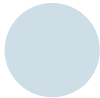
Client Health History: Needling/Collagen Induction Therapy Intake



Name: ______________________________ Date of Birth: ______________

Address: ______________________ City: ________________ State: ________ Zip: ________

Home/Cell Phone: ______________________ Work: ______________________

Email: ______________________________ Preferred Contact: Cell____ Work ____ Email _____

Emergency contact name: ______________________ Phone ______________

Relationship to you: ______________________________

Are you over the age of 18 years? ❑ Yes ❑ No

SKIN TYPE: Review the skin types below, using the Fitzpatrick Scale, and check the one that best describes your skin. This information will be used by your technician to determine the most appropriate way to approach your treatment(s):

❑ I. Very fair skin; blonde or red hair; light-colored eyes; freckles common
❑ II. Fair skinned; light hair, light eyes
❑ III. Very common skin type; fair; eye and hair color vary
❑ IV. Mediterranean Caucasian skin; medium to heavy pigmentation
❑ V. Mideastern skin; rarely sun sensitive
❑ VI. Black skin; rarely sun sensitive

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? ❑ Yes ❑ No

Please list the products you use regularly:

Facial Cleanser ______________________

Toner ______________________

Scrubs ______________________

Retinol ______________________

Enzymes ______________________

Moisturizer ______________________

Serum ______________________

Sunscreen ______________________

Glycolic Acid ______________________

Peptides or Growth Factors ______________________

Cosmetic History

Have you had needling or collagen induction therapy in the past? Yes___ No___

If yes, what area was treated? ______________________________

Are you prone to keloid or hypertrophic scarring? Yes____ No_____

Have you ever had any of the following injectables or implants?

Botox	Radiesse	Perlane	Collagen	Dysport
Juvederm	Restylane	Silicone	Sculptra	

Other: ______________________________

If yes, when? ____________ What body area(s)? ______________________

Continued ➪

Have you had any recent cosmetic surgeries/procedures? Yes ___ No___ If yes, when? ____________________
What body area? ____

Have you used Accutane in the past year? Yes____ No____
When were you last exposed to the sun (including tanning beds)? ____

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? Yes ___ No___ If yes, please describe ____
____

Do you have any tattoos in the area to be treated? Yes___ No___

Health History
Have you had chemotherapy in the past 6 months? Yes___ No_____
Do you have any of the following conditions:
____Psoriasis ____Eczema ____Dermatitis ____Pregnancy and/or breastfeeding ____Autoimmune disease
____Herpes Simplex ____Diabetes ____Heart disease and/or heart defects ____Hemophilia
____Collagen Vascular Disease ____Active acne

Do you have any other health condition not mentioned here? Yes___ No___
If yes, please list ____

Do you have moles/skin growths in the area to be treated? Yes___ No___
Have you ever had a reaction at the dentist or any other time from numbing? Yes___ No___
Do you have any allergies to medications, food, latex, topical products, and/or other substances?
Please list ____

Have you consumed drugs or alcohol in the last 24 hours? Yes___ No___
Please list all vitamins and supplements including herbal remedies you take regularly _________________
____

Please list all current medications including aspirin, ibuprofen, blood thinners, etc. you take regularly __________
____

Is there anything else you would like us to know? ____
____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures.

Client Name (Printed) ____

Client Name (Signature) ____ Date: _________

Esthetician/Technician: ____ Date: _________