TREATMENT LOG

Patient:	Age:	Sex:	DOB:
Physician Signature:	Treatment By:		

Skin Issues of Concern: Laxity Coarse lines Fine Lines Scars Stretch marks Pigmentation

Circle areas to be treated:

Other_____

Pre-Treatment Record:

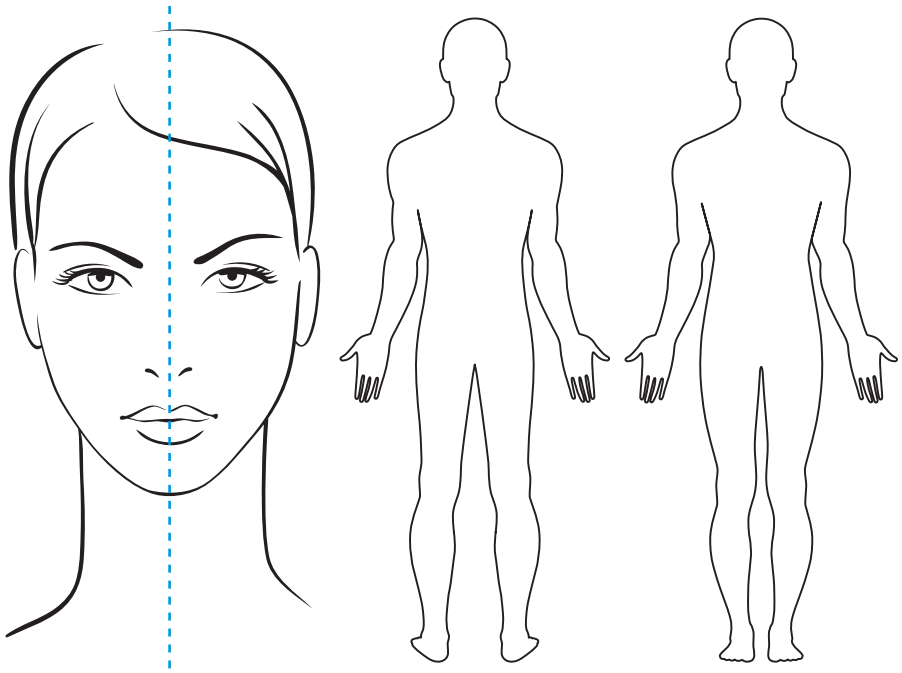
Consent Form Signed ☐ Yes ☐ No

Pain Relief Option Chosen:

☐ Topical- TAC BLT Other
☐ Local/Lido+Epi
☐ Local/Lido
☐ Regional
☐ Other _____

Post-Treatment Photography:

☐ Yes ☐ No



	Session One	Session Two	Session Three	Session Four
Date of Treatment				
Area of Treatment				
Device Type				
Needle Length				
Topical Products Applied				
Visible Signs : erthema, pin-point bleeding, frank bleeding, ecchymosis				
Treatment Notes				

PATIENT INFORMATION & CONSENT

Description of treatment:

Microneedling (also known as dermal needling or collagen induction therapy) consists of the creation of thousands of microscopic perforations in the upper layers of the skin using stamps, rollers, or electrically powered mechanical devices. This minor controlled trauma initiates a natural healing process that promotes general skin rejuvenation. -

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Mr / Mrs / MS / other:	First Name:	Surname:	
Address:			
Tel Home:	Tel Work:	Mobile:	
Emergency Contact Name:		Contact Number:	
Relationship to person:			
Email:	Date of birth:	Occupation:	
Pain relief option chosen:			
Topical applied at:	Removed at:	Amount of Plasma made:	ml
Area/s to be treated today:			

Previous surgical and non-surgical facial treatments .

Previous cosmetic procedures in areas treatment including fillers and Botox.

PATIENT INFORMATION & CONSENT

Contraindications:
Needling is contraindicated on irritated skin, infected skin, fungal skin infections, active acne, active rosacea, eczema, psoriasis, severe solar keratosis, skin cancer, raised moles and/or warts, and/or any open wounds or sores.

Patients with a history of herpes should discuss the details of their outbreaks with the physician. Depending on history, it may be necessary to initiate oral prophylaxis for a day or two prior to and after treatment.

Comments:

If you are unsure about any of above mentioned conditions, please ask!
Have you ever been told that you suffer from or suspect you suffer from: Platelet dysfunction syndrome, critical thrombocytopenia, hypofibrinogenaemia, haemodynamic instability, sepsis, chronic liver disease, Hepatitis or any acute or chronic infections?

YES / NO (circle one)

if yes, please state:

Medications and Allergies:

List all medications that you are currently taking or have taken in the last week:

(prescription, herbal, and over the counter meds)_____

Have you taken antibiotics in the last week? Y / N Specify _____

Are you allergic to medications? (include prescription and over the counter meds, and the type of reaction)

_____

Are you allergic to latex, lidocaine or any lotions? Y / N_____

Are there any open wounds or infections in the area being treated? Y / N _____

Medical History: (check all that apply)

- ☐ Bleeding Disorders
- ☐ Burns/Skin Grafts
- ☐ Diabetes
- ☐ Endocrine Disorders
- ☐ Epidermolysis Bullosa
- ☐ Gold Therapy
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hirsutism
- ☐ Scars
- ☐ Keloid Scars
- ☐ Lupus
- ☐ Permanent Makeup
- ☐ Polycystic Ovarian Dx
- ☐ Precocious Puberty
- ☐ Psoriasis
- ☐ Seizures
- ☐ Shingles
- ☐ Skin Cancer
- ☐ Tattoos
- ☐ Thyroid Disease
- ☐ Stain
- ☐ Port Wine Stain
- ☐ Herpes

PATIENT INFORMATION & CONSENT

Name of your family doctor _____Phone number _____

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 technician, esthetician, therapist, nurse, or doctor of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date _____