NYPRO SPA | | Microchanneling Screening Form

NAME……..
ADDRESS……
CITY……STATE……ZIP……
PHONE……EMAIL……
REF BY……AGE……BIRTHDAY……GENDER……
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PLEASE CIRCLE YES OR NO:

YES NO Are you over 18 years of age?
YES NO Do you take aspirin or blood thinners regularly?
YES NO Have you had any injectables in the past 30 days?
YES NO Have you taken any mood altering drugs in the last 8 hours?
YES NO Do you have a history of cold sores, herpes, and/or fever blisters?
YES NO Are you sensitive to Latex?
YES NO Have you recently had a chemical peel and/or laser peel treatment? If so, please indicate when:_____
YES NO Do you have trouble healing?
YES NO Are you currently undergoing radiation or chemotherapy?
YES NO Are you currently using any of the following: Retin-A, AHA, or other exfoliants
YES NO Are you allergic to any metals?
YES NO Are you currently taking any anti-inflammatory medications and/or steroids?
YES NO Are you allergic to any anesthetics, (any of the "-caines")?
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 any vitamin-A or vitamin-E in any form?
YES NO Are you pregnant or nursing?
YES NO Are you currently being treated by a dermatologist? If so, please indicate Why:_____

PLEASE CIRCLE ANY THAT APPLY TO YOU:

YES NO Heart Condition
YES NO Hepatitis
YES NO HIV
YES NO Cold Sores
YES NO Hyper-Pigmentation
YES NO Steel-Allergy
YES NO Smoking
YES NO Diabetes
YES NO Compromised Immunity
YES NO Chronic Skin Disease
YES NO Hemophilia
YES NO Accutane-Use in the last 2 years

Practitioner's Name: ***Homayra Razawi***

Practitioner's Signature:_____

NYPRO SPA | | Microchanneling Consent Form

Patient Name:_____Date:_____

I authorize **Homayra Razawi of NYPRO Spa, LLC**
to perform microchanneling on my skin, also known as microneedling, as well as to apply any and all topical preparations as determined necessary.

I understand that microchanneling is a non-ablative skin rejuvenation treatment and 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 that there is a possibility of short-term effects such as reddening, peeling, scabbing, temporary bruising, and/or temporary discoloration of the skin, as well as the rare side effects of infection and/or scarring. These effects have been fully explained to me.

Clinical results may vary depending on individual factors, including medical history, amount of existing 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, its 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 process is based solely on my expressed desire to do so.

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

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 treatment authorized herein.

Signature:_____Date:_____

NYPRO SPA | | Microchanneling Treatment Chart

Patient Name:_____Date:_____

DATE	AREAS	NEEDLE DEPTHS	# PASSES

Recommendations for future treatment:

_____

Notes:

_____

_____

Practitioner Sign-Off:

Signed:_____Date:_____
Signed:_____Date:_____
Signed:_____Date:_____
Signed:_____Date:_____
Signed:_____Date:_____
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