



Microneedling Consent Form Template

To the patient: Being fully informed about your condition and treatment helps you decide whether to proceed with microneedling. This information is here to ensure you make an informed choice or withhold consent if needed.

• Client Information

Full name: _____ Date of birth: _____

Gender: ☐ Female ☐ Male ☐ Non-binary ☐ Prefer not to say

Address: _____

Phone Number: _____ Email: _____

• Skin Type & Conditions

1. Which of the following applies to your skin type?

☐ Normal ☐ Dry ☐ Sensitive ☐ Oily ☐ Aging ☐ Rosacea ☐ Acne ☐ Combination

2. What areas of concern do you have regarding your skin? (please check all that apply)

☐ Breakouts/Acne ☐ Uneven skin tone ☐ Excessive oil/Shine ☐ Dull/Dry skin
☐ Broken capillaries ☐ Dehydrated ☐ Blackheads/Whiteheads ☐ Sun damage
☐ Wrinkles/Fine lines ☐ Rosacea ☐ Redness/Ruddiness ☐ Sun, brown spots
☐ Other: _____

3. Have you ever had an adverse reaction to a cosmetic product?

☐ No ☐ Yes If yes, please explain: _____

4. Do you have any special skin problems or concerns pertaining to your face or body?

☐ No ☐ Yes If yes, please explain: _____

• Current skincare routine

1. Have you ever had a facial treatment before?

☐ No ☐ Yes

If yes, please tell us when: _____

2. Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, or Retinol/vitamin A derivate products?

☐ No ☐ Yes

If yes, please list the ones you use: _____

3. Have you used any of these products in the last 3 months?

☐ No ☐ Yes

4. Have you used an acne medication?

☐ No ☐ Yes

If yes, please tell us which medication and when did you last take it: _____

5. What skincare products are you currently using? (List the brand where known)

6. Have you recently used any self-tanning lotions, creams, or treatments?

☐ No ☐ Yes

If yes, please specify: _____

7. Have you used any hair removal methods in the past six weeks?

☐ No ☐ Yes

If yes, please mark all that apply:

<input type="checkbox"/> Shaving	<input type="checkbox"/> Plucking	<input type="checkbox"/> Waxing	<input type="checkbox"/> Tweezing
<input type="checkbox"/> Electrolysis	<input type="checkbox"/> Stringing	<input type="checkbox"/> Depilatories	

8. What areas of concern do you have regarding your skin (please check any that apply)

<input type="checkbox"/> Breakouts/acne Blackheads/whiteheads	<input type="checkbox"/> Flaky skin	<input type="checkbox"/> Excessive oil/shine	<input type="checkbox"/> Uneven skin tone
<input type="checkbox"/> Rosacea	<input type="checkbox"/> Sun damage	<input type="checkbox"/> Broken capillaries	<input type="checkbox"/> Wrinkles/fine lines
<input type="checkbox"/> Redness/ruddiness	<input type="checkbox"/> Dull/dry skin	<input type="checkbox"/> Sunspot /liver spot/brown spot	
<input type="checkbox"/> Dehydrated	<input type="checkbox"/> Other: _____		

• Lifestyle habits

1. How would you describe your daily diet?

- ☐ **Balanced:** I eat a variety of fruits, vegetables, proteins, and whole grains
- ☐ **High Protein:** My diet is rich in proteins like meat, fish, eggs, or plant-based proteins
- ☐ **High Carb:** I consume a lot of bread, pasta, rice, and other carbohydrates
- ☐ **Low Carb/Keto:** I limit carbs and focus on fats and proteins
- ☐ **Vegetarian/Vegan:** My diet is plant-based with no animal products
- ☐ **Fast Food/Processed:** I often eat fast food or pre-packaged meals
- ☐ **Irregular:** My meals are inconsistent or unplanned

2. How much water do you drink in a day?

- ☐ Less than 1 liter
- ☐ 1-2 liters
- ☐ 2-3 liters
- ☐ More than 3 liters

3. What is your current stress level on a scale of 1-10?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10

4. How many hours of sleep do you get on average?

- ☐ Less than 5 hours
- ☐ 5-6 hours
- ☐ 6-7 hours
- ☐ 7-8 hours
- ☐ 8+ hours

5. Do you smoke?

- ☐ Yes
- ☐ No

6. How often do you consume alcohol?

- ☐ I don't consume alcohol
- ☐ Occasionally (1-2 times a month)
- ☐ Regularly (1-2 times a week)
- ☐ Frequent (3-4 times a week)
- ☐ Daily

7. How often are you exposed to the sun?

- ☐ Rarely (less than 1 hour per week)
- ☐ Occasionally (1-2 hours a few days a week)
- ☐ Moderately (2-4 hours on most days)
- ☐ Frequently (More than 4 hours daily)

• **FOR FEMALE CLIENTS ONLY**

Do you take any oral contraceptives?

☐ Yes ☐ No

If yes, please specify: _____

Please check any of the following that apply to you:

☐ Pregnant or trying to conceive

☐ Lactating

☐ Menopause

☐ Hormone replacement therapy

Description of the procedure

Microneedling is a minimally invasive cosmetic procedure that involves using a device with fine needles to create tiny punctures in the skin.

These micro-injuries trigger the body's natural healing process, stimulating collagen and elastin production.

The result is smoother, firmer, and younger-looking skin. Microneedling procedures use a sterile needle head and are safe and precise.

Depending on the required treatment and anatomical site, the procedure is normally completed within 30-60 minutes.

• **What to expect**

- Microneedling is generally well-tolerated, with a mild prickling sensation.
- A topical anesthetic is applied to reduce discomfort during treatment.
- Skin may appear red, like a sunburn, for a few hours post-treatment.
- Minor bleeding and bruising may occur, depending on needle length.
- Skin may feel warm, tight, or itchy, typically subsiding within 12-48 hours.

• **Post-treatment care**

- Avoid direct sunlight for at least 48 hours post-treatment.
- Avoid using retinoids, acids, or harsh exfoliants for 3-5 days after the treatment.
- Use gentle, moisturizing & hydrating products like hyaluronic acid to support the healing process.
- Avoid applying makeup for 24-48 hours to prevent irritation or infection.
- Avoid activities that cause excessive sweating, like intense workouts or saunas, for 72 hours post-treatment.
- No picking or scratching at the skin, even if flaking occurs.
- Stick to gentle, non-irritating cleansers during the recovery period

• Contraindications

- Side effects are minimal, usually involving minor flaking or dryness.
- Milia (small white bumps) may form and can be removed by the practitioner.
- Rare hyperpigmentation may occur, resolving within a month.
- Cold sore flare-ups may happen for those with a history of them.
- Temporary redness and mild sunburn effects can last up to 4 days.
- Freckles may lighten or disappear temporarily.

• Consent to treatment and photography

1. Do you understand the risks and benefits of the treatment being performed?

☐ Yes ☐ No

2. Do you consent to proceed with the recommended treatment?

☐ Yes ☐ No

3. Do you agree to have before-and-after photos taken for medical records?

☐ Yes ☐ No

If you have any additional questions or concerns before proceeding with the treatment, please add your questions below:

• Acknowledgement and understanding

I agree that the microneedling procedure, its benefits, and risks have been explained to me.

I am fully aware of and accept the risk of rare and unforeseen complications which may result from this treatment.

I understand that if I have any concerns, I will address them with my skin care specialist.

I give permission to my skincare specialist to perform the micro-needling procedure we have discussed and will hold them and their staff harmless and nameless from any liability that may result from this treatment.

I have accurately answered the questions above, including all known allergies, prescription drugs, conditions, or products I am currently ingesting or using topically.

I have read and fully understand the above paragraphs and had sufficient opportunity for discussion to have any questions answered.

I understand the procedure and accept the risks.

• Client and practitioner signature

Client name: _____

Practitioner signature: _____

Client signature: _____

Date: _____