

## 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 _____	Moisturizer _____
Toner _____	Serum _____
Scrubs _____	Sunscreen _____
Retinol _____	Glycolic Acid _____
Enzymes _____	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 ⇨

## Client Health History: Needling/Collagen Induction Therapy Intake 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: \_\_\_\_\_