Striving FOR Health

Microneedling Intake Form

Name:_____ Date:_____

Address:_____

Home phone number:_____ Cell number:_____

Email address:_____

Occupation:_____ Age:_____ DOB:_____

How did you hear about the clinic?_____

Would you like to receive our e-newsletter containing health and treatment tips?_____

Personal Medical History:

Are you presently in a physician's care?_____ If yes, why?_____

_____

Any major surgeries, illnesses, or accidents? If so, please list with dates _____

_____

Any contagious diseases? If so, please list. (ie. HIV, Hepatitis, herpes, etc)

_____

Any known allergies? If so, please list.

_____

Are you currently taking any medications? If so, please list.

_____

Are you currently taking any supplements or vitamins? If so, please list.

_____

Do you smoke?_____ If so, how much per day?_____

Do you consume alcohol?_____ If so, how often? _____

Do you exercise regularly?_____ What types of exercise do you prefer?_____

_____

Do you have an outlet for stress? _____

Are you staying hydrated daily? _____ How much water do you drink? _____

What is your diet like? _____

_____

Are you in the sun often? _____ Do you wear protective gear or sunscreen? _____

Do you have a history of using sun beds or bad sunburns? _____

Are you getting enough sleep every day? _____

Please check any health conditions which you have had or are now experiencing:

Active Acne	Heart Problems	Psoriasis
Active Rosacea	Hepatitis	Raised Moles or Warts
Allergies	Hives/ Itching	Recent Illnesses
Anemia	Immune Disorders	Reduced Skin Sensation
Cancer	Infections	Respiratory Issues
Cold Sores	Irritated Skin	Seizures
Depression	Light Sensitivity	Severe Solar Keratosis
Diabetes	Migraines / Headaches	Skeletal Problems
Easily Bruised	Muscular Conditions	Skin Problems
Eczema	Open wounds	Spinal Problems
Epilepsy	Pacemaker	Thrombosis
Fatigue	Phlebitis/Vein Inflammation	Tumors
Fungal Skin Infections	Pain (describe below)	Other (describe below)

Any major illnesses _____ If so, what? _____

Have you received radiation treatments on the skin within the last year? _____

Do you have a history of keloid or hypertrophic scars or poor wound healing? _____

Have you used Accutane (isotretinoin) within the last 3 months? _____

Are you pregnant or breast feeding? _____

Are you on any medications that cause increased photosensitivity? _____

Are you taking any anticoagulant medications, such as Coumadin? _____

Are you taking any blood thinning medications? _____

Cosmetic History Questions:

Do you have any sensitivities to specific products? _____ If yes, please list:_____

_____

What is your daily facial routine? _____

_____

_____

Do you use facial masks regularly? _____

How often are you exfoliating? _____

What type of products do you use? _____

What type of makeup do you wear? _____

Have you had cosmetic surgery? _____ If so, please list procedures: _____

_____

Do you get in office cosmetic procedures? _____ How often?_____

Which ones:

Botox	Dermal Fillers	Microdermabrasion
Chemical Peel	Juvéderm	Restylane
Cosmetic Tattoo	Laser Hair Removal	Silicone Injections
Dermabrasion	Laser Skin Resurfacing	Other

Any other health related concerns? _____

_____

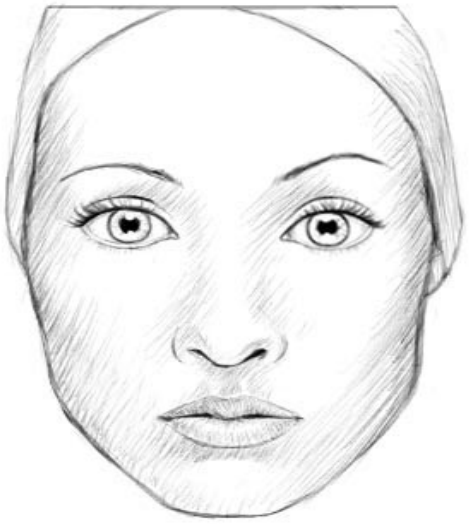
What are you hoping to achieve with the Micro-needling Facial Treatment? _____

_____

What are your main areas of concern? _____

_____

Please indicate any specific cosmetic concerns on the drawing below and add any comments about the areas. Please be precise and prioritize your concerns.



1._____

2._____

3._____

4._____

Any other concerns to discuss? _____

_____

_____

Striving FOR Health

Informed Consent for Microneedling Facial Treatment

Patient Name:_____

Acupuncturist: DeBritt Ealey, L.Ac. Clinic Name: Striving for Health

Consent: I hereby request and consent to Microneedling facial treatments by the acupuncturist named above and/or other licensed acupuncturists who now, or in the future, treat me while employed by, working or associated with, or serving as back-up for, the acupuncturist named above, including those working at the clinic or office listed above or any other office or clinic whether signatories to this form or not. Treatments are by appointment only. I understand that a Microneedling treatment is not a surgical procedure and is in no way intended as a substitute for cosmetic surgery.

Striving for Health does not provide primary care, nor Western (allopathic) medical care. Please see your medical doctor for those services and for routine check-ups. If you are pregnant, have a bleeding disorder, pacemaker, high blood pressure, local infection, or have been prescribed anticoagulant medications like Coumadin, we can still treat you but should be made aware of your condition. By signing below you state that you have informed your acupuncturist of such conditions.

Type of Care:

Microneedling – Collagen Induction Therapy

I understand that Cosmetic Acupuncture (including Microneedling) involves the insertion of special needles into particular points on the body. I have had an opportunity to discuss with the acupuncturist named above about the nature and purpose of the Microneedling treatment to which I am consenting. I consent to the treatment of MicroNeedling to be carried out upon myself.

The MicroNeedling treatment allows for controlled induction of growth factor serums or hyaluronic acid, into the skin's self-repair process by creating micro injuries in the skin. These injuries stimulate new collagen production, while not posing the risk of permanent scaring. The result is smoother, firmer and younger looking skin. The skin needling treatments are performed in a safe and precise manner with a sterile needle head and are usually completed in 30-60 minutes.

There are some risks to treatment, including the possibility of bruising of the skin and/or slight bleeding at the treatment sites. There are also other contraindications for this therapy.

LED Light Therapy

I understand that LED Light Therapy may be used to enhance the Microneedling benefits and reduce inflammation to the area treated. It is a completely safe and painless technique with no side effects. However, there are some contraindications for this therapy.

I understand that my treatment may be modified to address: 1) Changes in my condition, 2) Changes in my desired results, or 3) Changes in the professional standards of acupuncture care. I understand and agree to adjustments in my treatment as needed to optimally address my wellbeing, my objectives, and to take advantage of the full range of care options for me.

Potential Benefits: I understand that the purpose of Microneedling treatment is to create a younger and more vibrant appearance. This may include enhanced skin tone, improved luster of complexion, elimination or reduction of fine lines and wrinkles, decrease in hyper-pigmentations, a firming of sagging skin, and a lessening of the visible signs of aging. However, I understand that as with all TCM care, Microneedling treatments involves a gradual, healthful process that is customized for each individual, and that results may vary. While Cosmetic Acupuncture and Microneedling has been clinically shown to work; please note that everyone's body, skin, and repair process works differently. Please be advised that this treatment is not a surgical procedure and cannot be compared to a surgical facelift

No Guarantee: I understand that results are not guaranteed. My questions regarding longevity of results and potential changes in my facial appearance have been answered. I understand that although good results are hoped for, there is no guarantee or warranty, either expressed or implied, of the results that may be obtained.

Risks and Contraindications for Microneedling:

I understand that every procedure involves a certain amount of risk, including Microneedling treatments. Some of the more commonly seen side effects are listed immediately below, followed by contraindications and cautions.

Common Side Effects of Microneedling:

- Skin will be pink or red and may feel warm, like mild sunburn after treatment
- Skin can become tight and itchy, this usually subsides in 12 to 24 hrs.
- Minor flaking or dryness of the skin can occur, with scab formation in rare cases.
- Crusting, discomfort, bruising and swelling may occur after the treatment.
- Freckles may lighten temporarily or permanently disappear in treated areas.

Contraindications for this treatment:

- Accutane within 6 months
- Scleroderma
- Collagen vascular disease
- Active Rosacea
- Active Acne
- Blood clotting problems
- Platelet abnormalities
- Facial cancer, past and present
- Chemotherapy
- Steroid therapy
- Dermatological diseases affecting the face (i.e. Porphyria)
- Active bacterial or fungal infections over the treatment area
- Scars less than 6 months old
- Botox or facial fillers done within the past 6 weeks.
- Treatment is not recommended for patients who are pregnant or nursing.

Precautions for this treatment:

- Keloid or raised scarring
- Eczema
- Psoriasis
- Actinic keratosis (AK)
- Herpes Simplex
- Anticoagulation therapy (i.e.: Warfarin)

I understand and am informed that even though most patients do **not** experience complications from this type of treatment, some complications could arise for me, such as:

- **Bleeding and Bruising:** As with acupuncture in general, some minor bleeding may occur during treatment. This is normal and usually will not leave a bruise. Rarely, a bruise or a hematoma may appear. Topical and internal remedies will be discussed to address bruising should it happen. If swelling persists, I understand, I should call my provider immediately.
- **Infection:** There is little to no risk of infection for this treatment when all needles are sterile. Striving for Health uses only one-time use, sterile disposable needles. However, if I see any signs of tender redness or pus, I will notify the office immediately.
- **Cold Sore Flares:** If there is a history of cold sores this treatment could cause a small flare with that symptom. I understand this and will notify my practitioner before treatment begins, so they are aware.
- **Allergic Reactions:** In rare cases, local allergies to topical preparations can happen. Allergic reactions may require additional treatment or discontinuation of treatment.
- **Hyperpigmentation:** Darkening of the skin is rare to occur but if it should, it will usually resolve itself after a month.

- **Delayed Healing:** Delayed healing is a rare complication. Smoking and certain health conditions such as diabetes or vitamin deficiencies, to name a few, may delay the healing response of any of the aforementioned risks.
- **Unsatisfactory Results:** There is the possibility of a poor result from a Microneedling procedure. You may be disappointed with the results.
- **Alternative Treatment:** I understand that other alternatives exist for cosmetic care including but not limited to surgery, such as a surgical facelift, chemical face peels, injections, fillers, or botox. I realize that there are also risks and potential complications associated with these alternative forms of treatment.
- **Unsatisfactory Results:** I understand that I am not having a surgical procedure. The alternatives, risks, and comparisons of surgical procedures versus Microneedling have been discussed with me and outlined in this document. Should I have any further questions, I will discuss them with my provider before treatment begins.
- **Long Term Effects:** Following Microneedling treatments, changes in facial appearance may occur as the result of the normal process of aging, weight loss or gain, sun exposure, stress, illness, or other circumstances not related to Microneedling treatments. It has been explained that following lifestyle and dietary instructions may enhance the longevity of the Microneedling treatment while non-compliance will adversely affect the longevity of the Microneedling treatment. Additional, future treatments may be necessary to maintain the results.
- **Unforeseeable Impacts:** There are many variable conditions, in addition to the risks and potential complications enumerated that may influence the long term result from Microneedling. While the complications cited are the ones particularly associated with Microneedling, this is not an exact science, and other less common complications may arise. Should these or other complications occur, other treatments might be necessary.

Additional therapies used with Microneedling Treatments

Risks and Contraindications for LED Light Therapy

Some of the contraindications for LED Light Therapy are as follows:

- Epilepsy
- Photosensitivity of eyes or skin
- Currently Taking medications or herbs that cause photosensitivity
- Migraines brought on by bright light
- Currently taking steroid medications

I understand that if I experience and of these things that I should not have the LED light therapy done in conjunction with the Microneedling treatment. I will let my practitioner know before the treatment if I experience any of these issues.

Unforeseen Conditions: I understand that there are several styles or methods of facial, cosmetic, or rejuvenation acupuncture and I have been informed that during the course of Microneedling treatments, unforeseen conditions may necessitate different procedures than those listed above.

Agreement and Continuous Effect: I have been informed about the treatment, procedure, indications, expected results and possible side effects.

I am undergoing treatment of my own free will and I consent to this treatment being performed on me. I agree that this procedure is being performed for cosmetic reasons. I am also aware of and accept the risk of unforeseen complications that may not have been discussed and which may result from this treatment.

I have read, or have had read to me, the above consent. It has been explained to me in a way that I understand: a) The risks and contraindications involved with Microneedling, b) The contraindications involved with LED light therapy c) That I have alternatives available to me for cosmetic improvements, and d) What protocols will be used in connection with treatment. I have also had an opportunity to ask questions regarding the Microneedling and LED Light treatment, and I am satisfied that all my questions have been answered.

I acknowledge that no guarantee has been given to me by anyone as to the results that may be obtained by the treatments. I authorize the release of medical information, when required. Finally, by signing below I acknowledge that I have been fully informed about, and agree to, Microneedling with LED Light Therapy treatments. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I acknowledge my obligation to follow the instructions closely and visit the office as directed. I also agree to hold harmless and release from any liability Striving for Health or any of its officers, directors and / or employees for any condition or result, known or unknown that may arise as a result of any treatment that I receive.

Patient Signature:

Date:_____

Office Signature:

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451B Carlisle Dr. Herndon, VA 20170
debritt@strivingforhealth.com | www.strivingforhealth.com

Striving FOR Health

Diagnostic Examination Release

As an acupuncturist licensed in the state of Virginia, it is required that I ask if you have received a diagnostic examination within the past six months by a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Chiropractic (DC) acting within the scope of his/her practice for the issue(s) that we will be addressing in this office.

I have seen a doctor about my issue(s):_____

_____

If not, I am instructed to recommend that you get a diagnostic examination by a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Chiropractic (DC) acting within the scope of his/her practice for the issue(s)that we will be addressing in this office.

I have read and understand this information.

_____ _____

Signature Date

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