SKIN STUDIO KC

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CONFIDENTIAL

Microchannelling Screening Form

DATE _____
NAME _____
ADDRESS _____
CITY/STATE/ZIP _____
PHONE _____
EMAIL _____
DATE OF BIRTH _____

BOLD RED items are hard contraindications.

Yes	No	Are you over 18 years of age?
Yes	No	Do you take aspirin or blood thinners regularly?
Yes	No	Have you had injectables in the past 30 days?
Yes	No	Have you taken any mood-altering drugs in the past 8 hours?
Yes	No	Do you have a history of cold sores, herpes or fever blisters?
Yes	No	Are you sensitive to latex?
Yes	No	Have you had a chemical or laser peel? If so, when?
Yes	No	Do you have trouble healing?
Yes	No	**Are you currently undergoing radiation or chemotherapy?**
Yes	No	Are you currently using Retin-A, AHA, or other exfoliating skin care products?
Yes	No	Are you allergic to any metals?
Yes	No	Are you currently taking anti-inflammatory medications 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 vitamin A or E in any form?
Yes	No	**Are you pregnant or nursing?**
Yes	No	Are you currently being treated by a dermatologist?

Please check any that apply to you:

- ☐ Heart condition
- ☐ Cold sores
- ☐ Compromised immunity
- ☐ Diabetes (uncontrolled)
- ☐ Hepatitis
- ☐ Hyperpigmentation
- ☐ Accutane in last 2 years
- ☐ Chronic skin condition
- ☐ HIV
- ☐ Smoker
- ☐ Allergic to steel
- ☐ Hemophilia

_____ Name

_____ Signature

_____ Practitioner

_____ Practitioner's Signature