



FACIAL TREATMENT INTAKE

(use this form for Microneedling, Mesotherapy,
Facial Rejuvenation Acupuncture, and Facial Cupping)

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: (H) _____ (Cell) _____

Date of Birth: ____/____/____ (YYYY/MM/DD) Age: ____ Sex: M / F / _____

Occupation: _____ Email: _____

By providing my email, I agree to receiving clinic email reminders, health updates, promotions, etc.

In case of emergency, who should we contact: _____

How did you find out about our services? _____

If referred by someone, what is their name? _____

Do you currently have any of the following on your face? Please check:

- | | | |
|--|--|---|
| <input type="checkbox"/> Wrinkles and fine lines | <input type="checkbox"/> Crow's feet | <input type="checkbox"/> Droopy eyelids |
| <input type="checkbox"/> Large pores | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Oily skin |
| <input type="checkbox"/> Pigmented skin | <input type="checkbox"/> Discoloration | <input type="checkbox"/> Acne Scars |
| <input type="checkbox"/> Double chin | <input type="checkbox"/> Acne | <input type="checkbox"/> Melasma |

Please check if you have or have had any of the following:

- | | |
|---|---|
| <input type="checkbox"/> sensitive skin | <input type="checkbox"/> clotting disorders, on blood thinners?: _____ |
| <input type="checkbox"/> using retinol/retinoid products | <input type="checkbox"/> cosmetic surgery, what/when?: _____ |
| <input type="checkbox"/> undergoing laser treatments or peels | <input type="checkbox"/> migraines |
| <input type="checkbox"/> on acne medication, topical anti-biotics | <input type="checkbox"/> have/had cancer, skin cancer, when?: _____ |
| <input type="checkbox"/> using glycolic peels | <input type="checkbox"/> herpes, any active herpes?: _____ |
| <input type="checkbox"/> excessive tanning of face | <input type="checkbox"/> telangiectasia (broken capillaries/spider veins) |
| <input type="checkbox"/> Botox, when?: _____ | <input type="checkbox"/> Dermal Fillers, when?: _____ |
| <input type="checkbox"/> allergic skin reactions, to what?: _____ | |

Please check if you have any contraindications for facial treatments:

- | | |
|--|---|
| <input type="checkbox"/> Problems with bleeding (such as hemophilia, clotting disorders) | <input type="checkbox"/> Problems with bruising |
| <input type="checkbox"/> Former cosmetic surgery (caution only) | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Migraines, Diabetes Mellitus (if current) | <input type="checkbox"/> Sunburns |
| <input type="checkbox"/> Serious health conditions (such as cancer, AIDS, heart disease) | <input type="checkbox"/> Pregnancy (FRA/Cupping ok) |
| <input type="checkbox"/> Avoid ulcerated, irritated or bruised areas, warts | <input type="checkbox"/> Flus and colds |
| <input type="checkbox"/> Recent Botox or Dermal Fillers (must wait 2 weeks for substance to be absorbed) | |
| <input type="checkbox"/> Recent laser treatment, chemical peels, microdermabrasion (must wait 2 weeks due to thinned skin) | |
| <input type="checkbox"/> Acute herpes outbreaks and Acute allergic reactions (must wait until fully healed) | |

Please list any major chronic health conditions and allergies:

Consent for Treatment

Microneedling and **Facial Mesotherapy** are treatments that involve multiple injections into the mesoderm, the layer of fat and connective tissue just millimeters under the skin. The agents injected will vary from time to time but generally include nutrients such as vitamins, hyaluronic acid and other amino acids. It is very important to inform our practitioners of any disease/illness you currently have or have had in the past, current medications and if you are currently **pregnant**. Also inform us of any **allergies** or suspected allergies.

Possible complications of all Facial Treatments are minor bruising and bleeding at acupuncture and injection sites, dizziness, headaches and possible fainting from the sight of blood. Although natural and organic facial products are used as a cleanser, toner and moisturizer during the treatment, there may be a slight chance for sensitivities and reactions to these products.

You should not expect our Practitioners to be able to anticipate and explain all risks and complications of the treatment and you are encouraged to discuss any questions and/or concerns with her prior to beginning the treatment. Side effects that can occur as a result of all Facial Treatments can include **itchiness, swelling, redness, lumps, bumps, nodule formation, bruising, discoloration, worsening of pigmentation, scarring, blisters or ulceration, numbness, infection, dizziness, nausea, and possible allergic reaction to the substances used.**

By signing this consent form you agree that you understand that treatment results are variable for each individual and **cannot be guaranteed**. Treatment plans including duration and frequency of treatments are guidelines only and are subject to change according to individual progress. You understand that multiple treatment sessions are required. You acknowledge that all Facial Treatments provided at Essence Wellness Clinic, with its anti-aging role in increasing circulation and metabolism for the face, may not resolve any of your current facial conditions (such as wrinkles, bags or double chins), may cause a worsening in skin and will not prevent any future facial conditions which you may acquire as a result of sun damage or natural aging. You understand the fee schedule and agree to pay for all costs incurred.

Patients that should not undergo this procedure include: patients with a bleeding disorder, patients who are on blood thinners, women who are pregnant and patients with active skin infections.

By signing this consent form you agree that you have provided correct information about your health, you have read and understand all of the above, including the potential risks and side effects of treatment, and thereby authorize your informed consent to your entire course of all Facial Treatments by our practitioners and release them and Essence Wellness Clinic from any liability associated with their treatment.

Signature _____ Date _____
