

Customer:

Completed: 12 Feb 2026 - 9:37 AM

Email:

Device Name: iPhone Mobile Website

Phone:

IP Address: 45.223.192.9

Business Logo:

Location: Redwood City US



## Microneedling Consultation & Consent Form

Microneedling creates controlled micro-channels in the skin using sterile needles to stimulate collagen, improve texture, reduce scarring, enhance product absorption, and support overall skin rejuvenation. It works by triggering the skin's natural wound-healing processes (inflammation, proliferation, and remodelling). Results develop gradually over several weeks and may require 3-6 sessions depending on skin concerns. Temporary redness, sensitivity, and mild swelling are expected.

### 1. Client Demographic Information

First Name: Eleanor

Last Name: Fanning

Address: Castle Street, Norham, Northumberland, TD15 2LQ

Email: ellie.f@hotmail.co.uk

Phone: 07939617184

Gender: Not Answered

Birth Date: 25 Sep 1994

Referred by: Na

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## Medical History & Skin Analysis

**2. Are you currently under the care of a doctor or dermatologist?**

No

**3. If "Yes" please specify**

Not Answered

**4. Treatment Selection - Please select the treatment you're booked for:**

Microneedling with serum

**5. Do you have any of the following conditions? Please answer truthfully, this ensures your treatment is safe and effective**

None of the above

**6. If "Yes" to any of the above including current medication or other Medical Condition, please specify**

Not Answered

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**7. How would you describe your skin?**

Oily

**8. If "Other" please specify**

Not Answered

**9. What would you most like to improve?**

Breakouts or congestion

**10. Have you had any aesthetic treatment (facials, microneedling, injectables, etc) within the last 6 weeks?**

No

**11. Do you have askincare routine? if yes, please describe it**

Not really

**12. Are you currently on any of the following?**

None of the above

**13. When is this appointment scheduled?**

12 Feb 2026

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#### CONTRAINDICATION CHECK

Microneedling cannot be performed if absolute contraindications apply and may need postponement if relative contraindications are present. It is essential to answer honestly to ensure safe treatment.

Absolute Contraindications:

**14. Are you currently on any of the following?**

None of the above

Relative Contraindications:

**15. Are you currently on any of the following?**

None of the above

## Client's Consent (Mandatory)

**Photographs are taken before and after treatment for medical documentation and client records.**

### 16. Client Consent (Mandatory) Please confirm each statement:

I confirm that I have read, understood, and agree to follow the pre- and post-treatment information guide provided with this consultation and consent form, I confirm that the information I have provided is accurate, and I have disclosed all relevant medical history and allergies., I understand the general risks associated with aesthetic treatments, including bruising, swelling, asymmetry, infection, or temporary discomfort., I understand that results vary between individuals and that I may require further treatment for optimal or maintained results., I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction., I understand that all aesthetic treatments provide temporary results and will naturally wear off over time

### 17. Photo & Marketing Consent.

I do not consent to any use of my photos beyond my medical record.

### 18. Please sign and date to confirm that you have read, understood, and agree to the statements above.



X Customer's Signature

Feb 12, 2026 - 9:37 AM

**19. Client's Name**

Eleanor

X Employee's Signature

Feb 12, 2026 - 9:37 AM

**21. Employee's Name**

Fanning

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**Practitioner Notes (For Internal Use Only)**

Assessment:

Batch Number & Expiry Date:

Treatment Given / Units Used: