Hair Regrowth Screening Form

BOLD RED items are hard contra-indication

Name: ______________________ Date: ____________

Address: ______________________________________

City: ______________________ St: ________ ZIP: ____________

Home Phone: ______________________ Cell Phone: ______________________

Email: ______________________ Referred by: ______________________

Yes No Are you over 18 years of age?
Yes No Do you take aspirin or blood thinners regularly?
When did your hair start thinning? ______________________
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 other hair regrowth treatments? ______________________
Yes No Do you have trouble healing?
Yes No **Are you currently undergoing radiation or chemotherapy?**
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 Have you ever been diagnosed with “Male Pattern Baldness”?

Please circle any that apply to you:

Heart Condition	Hepatitis	HIV	Cold Sores
Hyper Pigment	Smoker	Compromised Immunity	**Accutane in last 2 yrs**
Allergic to Steel	**Diabetes (uncontrolled)**	**Chronic Skin Disease**	**Hemophilia**

Practitioner’s Name: ______________________________________

Hair Regrowth Consent Form

Patient name:___________________________________**Date:** _____________

I authorize ____to perform Microchanneling on my scalp, and to apply topical preparations as determined necessary.

I understand that Procell Microchanneling for hair regrowth is involves the creation of perforations in my scalp to promote delivery of product to reactivate follicles affected by Alopecia. I understand that the procedure is performed with an automatic perforating device and that clinical results may vary. I understand there is a possibility of short-term effects such as pain, reddening, peeling, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as infection & scarring. These effects have been fully explained to me.

Clinical results may vary depending on individual factors, including medical history, amount of, and longevity of hair loss, and my compliance with pre/post treatment instructions.

I understand that the Microchanneling treatment may involve a series of treatments and that the fee structure has been fully explained to me.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained, and that there are no refunds offered for lack of satisfactory results. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time. I also have completed a medical history checklist and been informed about what I must do and “not do” before, during and after the procedure.

I consent to the taking of photographs and authorize their anonymous use for the purposes of clinical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

I furthermore indemnify the authorized person herein, and hold harmless from any and all claims, demands, liabilities, judgments, costs and expenses arising out of any claims relating to the procedure authorized herein.

Signature: ______________________________________Date: ______________

Hair Regrowth Microchanneling Treatment Chart

Patient name:____

Date	Areas	Needle Depths	# Passes

Recommendations for Future Treatment:

____

• **Post care information given**

Notes:

____

____

Practitioner Sign Off:

Signed: Date:

Signed: Date:

Signed: Date:

Signed: Date:

Signed: Date:

Signed: Date:

Hair Regrowth Microchanneling Post-Care

1. If any Microchannel Delivery Solution roll-on remains, apply nightly with the Celage Hand Stamper.

2. No other products should be applied until the following day.

3. Avoid exposure to pet dander and other irritants as best you can. You may experience a mild allergic reaction to pets and other things you typically to dot react to within the first 24 hours.

4. When the numbing wears off your skin may feel like a mild sunburn. You may apply cool compresses as desired.

5. Beginning in the evening; roll on the Hair Regrowth Serum and stamp it in with the Celage stamper.

8. Peeling and skin sloughing may occur for several days after treatment.

9. Return for a follow up treatmentas instructed.

If prolonged irritation occurs, please **email or call** our office.

Practitioner Name: ____

Practitioner Phone #: ______________________________________

Practitioner Email: ____