|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Surname |  |  |  |  |  |  |  |  | First Name |  |  |  |  |  |
|  | Address |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | City |  |  |  |  |  |  | State |  |  | Postcode |  |  |  |  |
|  | Mobile |  |  |  |  |  |  | Work Ph | |  |  |  |  |  |  |
|  | DOB |  |  |  |  |  |  | Family | Doctor | |  |  |  |  |  |
|  | Gender |  | **M** | | **F** | *(Please circle)* | | Family | Doctor Phone | |  |  |  |  |  |
|  | Emergency Contact | | | |  |  |  |  |  | Emergency Contact Phone | |  |  |  |  |
| Which body area/areas or condition would you like treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |  |  |
| Please answer **ALL** the following questions: | | | | | | | |  |  |  |  |  |  |  |  |
|  |  | |  |  | | | |  |  |  |  |  |  |  |  |
|  | **Medical History Information** | | | | | | |  |  |  |  |  |  | **Please Circle** | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 1. Do you have ANY current or chronic medical illnesses? Disclose any history of heat urticaria, diabetes. | | | | | | | | | | | |  |  |  |
|  | autoimmune disorders or any immunosuppression, blood disorders. cancer, bacterial or viral infections, medical | | | | | | | | | | | |  | YES | NO |
|  | conditions that significantly compromise the healing response, skin photosensitivity disorders or any other | | | | | | | | | | | |  |
|  |  |  |  |
|  | condition or illness. | | | |  |  |  |  |  |  |  |  |  |  |  |
|  | Please List |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 2. Do you have ANY current or chronic skin conditions? Also disclose any history of vitiligo, eczema, melasma, | | | | | | | | | | | |  |  |  |
|  | psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin | | | | | | | | | | | |  | YES | NO |
|  | cancer, or any other skin condition. | | | | | | |  |  |  |  |  |  |  |  |
|  | Please List |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 3. Are you currently under a doctor’s care? | | | | | | |  |  |  |  |  |  | YES | NO |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | List Reason |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 4. Do you take/use ANY medications (prescriptions and non-prescription), vitamins, herbal or natural | | | | | | | | | | | |  | YES | NO |
|  | supplements, on a regular or daily basis? | | | | | | |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Please List |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 5. Are there ANY topical products (both medical and non-medical) that you use on your skin on a regular or daily | | | | | | | | | | | |  | YES | NO |
|  | basis? |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Please List |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 6. Do you take/use ANY systemic/oral steroids (e.g. prednisone, dexamethasone)? | | | | | | | | | | | |  | YES | NO |
|  |  | | | | | | | | | | | |  |  |  |
|  | 7. Do you have ANY allergies to medications? foods, latex or other substances? | | | | | | | | | | | |  | YES | NO |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Please List |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 8. Are you receiving, or have you received gold therapy? (rheumatoid arthritis) | | | | | | | | | | | |  | YES | NO |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | Medical History Information | |  | Please Circle | |
|  |  |  |  |  |  |  |
|  |  | 9. (For women) are you or could you be pregnant? | |  | YES | NO |
|  |  |  |  |  |  |  |
|  |  | 10. (For women) are your menstrual periods regular? | |  | YES | NO |
|  |  |  |  |  |  |  |
|  |  | 11. (For women) have you ever been diagnosed with Polycystic Ovarian Disorder? | |  | YES | NO |
|  |  |  |  |  |  |  |
|  |  | 12. Do you have a history of Herpes I or II in the area to be treated? | |  | YES | NO |
|  |  |  |  |  |  |  |
|  |  | 13. Do you have a history of Keloid scarring or Hypertrophic scar formation? | |  | YES | NO |
|  |  |  |  |  |  |  |
|  |  | 14. Do you have a history of light Induced Seizures? | |  | YES | NO |
|  |  |  |  |  |  |  |
|  |  | 15. Do you have ANY open sores or lesions? | |  | YES | NO |
|  |  |  |  |  |  |  |
|  |  | 16. Do you have ANY history of radiation therapy in the area to be treated? | |  | YES | NO |
|  |  |  |  |  |  |  |
|  |  | 17. In the last six (6) months. have you used ANY of the following? | |  | YES | NO |
|  |  | Anticoagulants or blood-thinning medications: photosensitizing medications: anti-inflammatory medications | |  |
|  |  |  |  |  |
|  |  | List Product name and date last used |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  | 18. In the last three (3) months, have you used ANY of the following products: glycolic acid or salicylic acid; | |  | YES | NO |
|  |  | alphahydroxy or betahydroxy acid products | |  |
|  |  |  |  |  |
|  |  | List Product name and date last used |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  | 19. In the last three (3) months, have you used ANY exfoliating or resurfacing products or treatments? | |  | YES | NO |
|  |  |  | |  |  |  |
|  |  | List Product name and date last used |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  | 20. Do you or have you ever had ANY permanent make-up, tattoos, implants, or fillers, including, but not limited to, | |  | YES | NO |
|  |  | collagen, autologous fat, Restylane etc. ? | |  |  |  |
|  |  | List locations on/in the body and dates |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  | 21. Do you or have you ever had ANY Botulinum’s such as Botox or Dysport etc. ? | |  | YES | NO |
|  |  |  | |  |  |  |
|  |  | List locations on/in the body and dates |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  | 22. Have you taken Accutane (or products containing isotretinoin) in the last 12 months? | |  | YES | NO |
|  |  |  | |  |  |  |
|  |  | 23. Have you taken Tretinoin (like Retin-A, Renova) in the last 6 months? | |  | YES | NO |
|  |  |  | |  |  |  |
|  |  | 24. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or | |  | YES | NO |
|  |  | tanning beds or lamps in the last 4-6 weeks? | |  |
|  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Patient signature |  |  |  |  | Dated |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

**POTENZA MICRONEEDLING/HEMOSTASIS AND ELECTROCOAGULATION**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_

As a client, it is important for you to understand the expected results and risks of radiofrequency microneedling treatment with the Potenza Microneedling System. Please read this document carefully. Before signing this document, please ask your physician, or the consultant providing the RF treatment, about any aspect of this document or the procedure that you do not understand.

Potenza System equipment may present a hazard to clients with implantable devices.

Please consult qualified medical personnel prior to being treated with radiofrequency equipment.

Since ongoing feedback by a client during a procedure is required, if there is nerve insensitivity to heat anywhere in the treatment area, the client should not be treated with the Potenza System.

All clients should be free of infection prior to application. Infection can further increase the risk of scarring; therefore, proper wound care is important in the prevention of infection. If signs of infection such as pain, heat, blisters or surrounding redness develop following application, call the provider’s office immediately.

Potenza treatments have not been studied for use on pregnant clients, clients with autoimmune disease, diabetes or herpes simplex.

**Potenza System**

The application will involve applying low level heat to the tissue using radiofrequency for therapeutic purposes.

NOTE: All clients are different and exact results of this cosmetic procedure and treatments cannot be predicted or guaranteed.

**During Treatment**

All jewelry and lotions should be removed from the treatment area prior to treatment.

The procedure should not be performed on cut, wounded or infected skin as this could promote infection and injury. Although uncommon, burns can occur.

Slight discomfort may be experienced while undergoing treatment. Typically, the discomfort is mild and temporary during the procedure and localized within the treatment area. During the treatment, you should provide ongoing feedback to the individual performing the treatment. Additionally, if you have nerve insensitivity to heat anywhere in the treatment area, you should not be treated. Inadequate or impaired feedback may lead to burns or injury. Ongoing feedback should be provided by the client to the individual performing the treatment to avoid excessive discomfort.

**After Treatment**

* Studies indicate the possible side effects of Potenza System are usually treatment-site related and include mild discomfort during the procedure, localized within the treatment area. Mild swelling and redness may occur, which typically goes away within 2 to 24 hours.
* A regimen to moisturize and soothe the external skin posttreatment is recommended.
* There is the possibility that additional risk factors of radiofrequency skin treatments may be discovered. The results of performing RF tissue-heating treatments in combination with other treatments is unstudied and unknown.
* It has been explained to me that more than one treatment may be recommended to achieve the best results. As mentioned before, there is no guarantee of results.
* My signature below signifies that all of my questions have been answered by the physician or consultant. I understand the risks, complications, expected results, and expense of the treatments. I have read and understand this document and give my consent to receive treatment with the Potenza System.

Client Name (Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner Name (Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment Record**



Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Implanted devices/metals discussed: Yes ☐No ☐N/A ☐

1st Treatment ☐ 2nd Treatment ☐ 3rd Treatment Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neutral Pad Connected? Yes ☐ No ☐ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Frequency** |  | **Auto (Hz)** |  | **Depth** | **Power** | **Pulse** | **Impact** |
| **TX Location** | **Tip ID** | **Polarity** | **HP** | **(0.5-4.0** |
| **(MHz)** | **(0.2 -3.0)** | **(W)** | **Width** | **(1-7)** |
|  |  |  |  | **or N/A)** |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  | ☐1 MHz | ☐Bi | ☐On | ☐AC |  |  |  |  |
|  |  | ☐2 MHz | ☐Mono | ☐Off | ☐Motor |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  | ☐1 MHz | ☐Bi | ☐On | ☒AC |  |  |  |  |
|  |  | ☐2 MHz | ☐Mono | ☐Off | ☐Motor |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  | ☐1 MHz | ☐Bi | ☐On | ☐AC |  |  |  |  |
|  |  | ☐2 MHz | ☐Mono | ☐Off | ☐Motor |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  | ☐1 MHz | ☐Bi | ☐On | ☐AC |  |  |  |  |
|  |  | ☐2 MHz | ☐Mono | ☐Off | ☐Motor |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  | ☐1 MHz | ☐Bi | ☐On | ☐AC |  |  |  |  |
|  |  | ☐2 MHz | ☐Mono | ☐Off | ☐Motor |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  | ☐1 MHz | ☐Bi | ☐On | ☐AC |  |  |  |  |
|  |  | ☐2 MHz | ☐Mono | ☐Off | ☐Motor |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  | ☐1 MHz | ☐Bi | ☐On | ☐AC |  |  |  |  |
|  |  | ☐2 MHz | ☐Mono | ☐Off | ☐Motor |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  | ☐1 MHz | ☐Bi | ☐On | ☐AC |  |  |  |  |
|  |  | ☐2 MHz | ☐Mono | ☐Off | ☐Motor |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  | ☐1 MHz | ☐Bi | ☐On | ☐AC |  |  |  |  |
|  |  | ☐2 MHz | ☐Mono | ☐Off | ☐Motor |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  | ☐1 MHz | ☐Bi | ☐On | ☐AC |  |  |  |  |
|  |  | ☐2 MHz | ☐Mono | ☐Off | ☐Motor |  |  |  |  |
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Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client’s tissue response:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Post care reviewed: ☐ Yes ☐No

Clinician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_

**PRE-TREATMENT GUIDELINES**

* Keep hydrated by drinking water (at least eight cups daily) or hydrating fluids to improve treatment outcomes.
* Avoid drinking alcohol for 24 hours in advance of treatment.
* For three to seven days prior to treatment, at the physician’s discretion, avoid therapies that may cause erythema (redness) or irritation, such as retinols or products containing isotretinoin and any exfoliating acid preparations.
* Shave visible hair from the treatment area.
* Male beards should be shaved on the day of treatment.
* The same procedure should be followed prior to each visit.

**POST-TREATMENT GUIDELINES**

* Do not scrub or exfoliate the skin.
* Wash the area with warm water and a mild cleanser.
* Do not apply liquid makeup for 24 hours; mineral makeup is acceptable after the erythema resolves.
* If erythema after treatment persists, use an ice pack (or frozen peas) at home, but always use a protective barrier, such as a face cloth, between the skin and the ice pack.
* Always wash your hands thoroughly before touching your face: there are micro-pathways opened into the dermis and hands will introduce bacteria.
* If skin feels tight or dry, apply moisturizing cream frequently.
* If you currently have skin breakouts, you may find that the condition may temporarily worsen due to inflammation or edema.
* Do not pick at treated tissue: doing so may result in hyper- or hypopigmentation.
* Avoid ultraviolet rays and apply sunblock >50 SPF UV A/B daily.
* Avoid alcohol consumption if possible.
* For 24 hours, refrain from high intensity aerobic exercise or activities that increase the body temperature like saunas, hot tubs, steam showers or exercise (i.e. jogging, weight training, kickboxing, etc.).
* Call your practitioner if any problems develop: concerns regarding rash, itching, erythema etc. for more than 24 hours