This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you!

Personal Information

Name_____D.O.B:_____Age_____ Date _____

Home
Address_____

City_____State_____ Zip_____

Phone_____ E-mail_____

Emergency Contact: Name_____ Phone:_____

Whom should we thank for referring you to our office? _____

Have you had acupuncture therapy before? □ Yes □ No With Whom? _____

Please indicate if any of the following pertain to you: (marking "yes" does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):

□ Hepatitis □ HIV □ High Blood Pressure □ Seizures □ Pacemaker □ Blood-Thinning Meds □ Pregnant □ Chronic Headaches/migraines □ Herpes outbreak □ Extreme Rosacea □ Cancer □ Prone to Bleeding

Please indicate the use and frequency of the following:

Coffee _____ Soda pop _____Water _____

Alcohol_____ Recreational drugs _____ Tobacco_____

Do you have any allergies to any medications? Yes_____ No_____

If so please list:_____

Are there any health conditions that need to be addressed_____

Please list any prescription or over-the-counter medications/supplements you are presently taking:

_____

_____

Please list typical day for the following?

Breakfast_____

Lucnch_____

Dinner_____

Snacks_____

Exercise (How often)_____

Please "check" the symptoms or conditions you experience frequently:

Earth	Fire	Metal	Water	Wood
__ excessive appetite	__ insomnia	__ cough	__ low back pain	__ eye problems
__ loose stool/diarrhea	__ palpitations	__ shortness of breath	__ knee problems	__ jaundice
__ digestive problems, indigestion	__ cold hands and feet	__ decreased sense of smell	__ hearing impairment	__ difficulty digesting oily foods
__ vomiting	__ nightmares	__ nasal problems	__ ear ringing	__ gall stones
__ belching, burping	__ mentally restless	__ skin problems	__ kidney stones	__ light-colored stool
__ heartburn/reflux	__ laughing for no reason	__ claustrophobia	__ decreased sex drive	__ soft or brittle nails
__ stomach bloating	__ chest pains	__ colitis/diverticulitis	__ hair loss	__ irritable, frustrated
__ obsession in work, relationships, etc.	__ poor memory	__ constipation	__ urinary problems	__ difficulty in making decisions
__ lack of appetite	__ bitter taste	__ blood in stool __ sadness	__edema	
		__ hemorrhoids	__ dental problems	__ high cholesterol
__ recent use of antibiotics				

Are you still menstruating?_____ Are you perimenopausal?_____Symptom:_____

Are you menopausal?_____ Symptoms:_____

What emotion or feelings do you express the most:
□ Worry □ Happy □ Sadness □ Fear □ Anger/Irritability □ Stress

Please list any surgeries or major health incidents (accidents, etc.) in your life:_____

_____

Beauty Evaluation

Have you ever received microcurrent treatment? _____When_____

Have you ever received cosmetic procedure (Botox, fillers, plastic surgery)?_____

Explain_____ How Long ago?_____

How much sun exposure do you get per week? _____

What are you major facial concerns? _____

What are you hoping to accomplish with Acu-Lift Facial?

_____

Do you have or have you ever had the following? (please check all that apply)

Skin Type: □ Normal □ Dry □ Combination □ Oily □ Sensitive

Skin Condition: □ Acne □ Eczema □ Itching □ Skin Cancer □ Skin Rashes □ Rosacea □ Skin Allergies

What skin care products do you use?_____

Consent Form

I,_____, consent to undergo acupuncture and non-needle microcurrent facial acupuncture treatment, knowing that there are no guaranteed results.

I acknowledge that I have been advised that using electrotherapeutic and cosmetic procedure could result in hematoma, bruise, puffiness, redness (bleeding) pain or other symptoms.

I completely understand and accept the above and agree to undergo the treatments, I accept the binding abrogation between patient and practitioner.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
PRACTITIONER DATE