Constitutional Acupuncture facial Rejuvenation

Acupuncture facial Intake Form

Information Confidential: Please print Date: ---------- -

Name: _____ Age____ Sex: M/F ----------

Email:_____

Address: _____ Occupation: _____

City:_____ State:_____ Zip:_____ Birth date: _____

Telephone:_____ Ext._____ Evening Phone/ cell:_____

Referred by:_____ Physician:_____

Have you ever had an acupuncture facial? _____ Do you bruise easily?_____

What medications are you taking?_____

For what condition?_____-

What vitamins are you taking?_____

Blood type:_____

Medical History: (check all that apply)

- AIDS/HIV
- Allergies To what?_____
- Asthma
- Cancer
- Emphysema
- Hepatitis/A/B/C
- Lyme disease
- Multiple sclerosis
- Polio
- Scarlet fever
- Tuberculosis
- Lymph nodes removed
- Other
- Alcoholism
- Allergies to cosmetics: To what?_____
- Birth trauma

- Diabetes
- Heart disease
- Herpes
- Mitral valve
- Pacemaker
- Rheumatic fever
- Seizures
- Latex allergy
- Varicose veins

Injuries, Surgeries, major illnesses:
Please provide details:_____
When? (date)_____
Diet: Food cravings?_____
Food Intolerances?_____
How many glasses/cups do you drink each day of the following?
Water_____ Soda_____ Coffee_____ Tea_____
Alcohol_____
How much do you consume(servings per day/week?)
Meat_____- Sugar/Sweets_____ Dairy_____
Do you perspire during the day or night?
Are you always thirsty? Y/N
Do you prefer hot/ cold beverages?
Taste Preferences(Indicates 1-5; 1= most liked; 5= disliked)
Salty_____ Sour_____ Bitter_____ Sweet_____ Spicy_____
GI
Do you have or have you had? (Check all that apply)
Belching_____ Nausea_____ Vomiting_____ Ulcers_____
Bloating_____ Indigestion_____
Hernia_____Hemorrhoids_____ Acid reflux_____
Bowel movements How often?_____ Day/week
Irregularity_____ Constitpation_____ Diarrhea_____ Gas_____
Burning_____
Exercise and Energy
What kind of exercise do you engage in?_____ How often?_____
How is your general energy level?_____-
Emotions and sleep?
Do you have or have you had? (check all that apply)
Panic attacks__ Depression_____ Anxiety_____ Nervousness_____
Fear_____ Poor memory_____ Difficulty concentrating_____ Do you take antidepressants?_____ What kind?_____

Do you take sleeping pills?_____What kind?_____
Do you have? (check all that apply)
Difficulty falling asleep_____ Restless_____Disturbed sleep_____
Waking up at a.m./p.m._____
Urination How often?_____ times per day Color_____
Do you have or have you had? (check all that apply)
Frequent urination_____ Incontinence_____ Burning_____ Bladder infections_____
GYN
Are you still menstruating?_____
Irregular Menses_____ heavy flow_____ Light flow_____ No flow_____
Blood clots_____PMS_____Painful Periods_____ Uterine Fibroids_____ Cystic Breasts_____
Are you Perimenopausal?_____ Symptoms_____
Are you menopausal?_____Symptoms_____
Respiratory, ENT and Head
Do you smoke? Y/N Times/ day for _____ years
Do you have or have you had?(check all that apply)
Frequent colds_____ Asthma_____ Dizziness_____ Cold sores_____
Bleeding Gums_____ Dry mouth_____ Ear pain_____ Ringing in ears_____ Frequent headaches_____ Migraines_____
Cardiovascular
Do you have or have you had? (Check all that apply)
Palpitations_____ Varicose veins_____ spider veins_____ Cold hands/ feet_____ Mitral valve_____ Poor circulation_____
Irregular heartbeat_____
Skin and hair
Do you have or have you had?(check all that apply)
Dry skin_____ Skin rashes_____Itching_____ Acne_____-
Eczema_____Hives_____Hair loss_____
Are there any additional health concerns that I should be informed of?_____
_____
Thank you!!