RELAXUPUNCTURE

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Facial Intake Form

Today's Date _____/_____/_____

Thank you for taking the time to complete the following information which will help me to better assess your health needs. You may be as brief as you like. All information is confidential.

GENERAL INFORMATION

Name _____Birthdate_____/_____/_____ Age_____ Pronouns _____

Address _____ City_____ State_____ Zip _____

Phone Numbers *(please mark * next to preferred number)*

Home _____ Cell _____ Work _____

E-mail address _____

Marital Status _____ #of children _____ their ages _____

Occupation _____ Hours worked per week _____

Employer & commute time _____

How did you hear about us? _____

If via person, who may we thank? _____

EMERGENCY CONTACT

Name _____ Phone _____ Relationship _____

HEALTHCARE PROVIDERS - PLEASE LIST THOSE YOU WORK WITH

Please list those you work with _____

_____

_____

_____

Previous experience with acupuncture? □ Y □ N With whom & results _____

If throughout my treatment any of the conditions on this form change, I will be responsible for notifying the practitioner.

The average number of treatments per series is ten. Some people may require additional treatments due to age, general health, lifestyle and/or the state and condition of the skin and muscle tone. A maintenance treatment is recommended on a regular basis. The average schedule for this is monthly. Photos may be taken throughout the program. Photos may be used for demonstration purposes.

Signature: _____ Date: _____

HEALTH HISTORY

Please list your major health concerns in order of importance to you: _____

_____

_____

_____

_____

Indicate those that apply to your past medical history:

- □ Adverse reaction to medical treatment
- □ Alcoholism
- □ Allergies
- □ Arthritis or rheumatism
- □ Asthma
- □ Attempted suicide
- □ Birth Trauma
- □ Bleeding disorder
- □ Blood disease
- □ Cancer or tumor
- □ Diabetes
- □ Emphysema
- □ Eating disorder
- □ Fibromyalgia
- □ Heart disease
- □ Hepatitis/Liver disease
- □ Herpes
- □ High blood pressure
- □ HIV/AIDS
- □ Immune disorder
- □ Joint replacement
- □ Kidney disorder
- □ Low blood pressure
- □ Lyme's disease
- □ Lymph nodes removed
- □ Mental illness
- □ Multiple Sclerosis
- □ Pacemaker
- □ Polio
- □ Rheumatic arthritis
- □ Rheumatic fever
- □ Sciatica
- □ Scarlet fever
- □ Seizures/Epilepsy
- □ Sinus infections
- □ Skin disease
- □ Special diet
- □ Stroke
- □ Substance abuse
- □ Thyroid disease
- □ Tuberculosis
- □ Ulcer
- □ Venereal Disease/STD
- □ Other Chronic or Contagious Diseases

_____

_____

List any serious diseases, injuries, surgeries, or hospitalizations you have had & the year they occurred:

_____

_____

_____

Please approximate dates & briefly describe the nature of any traumatic experiences you have had (e.g. divorce, injury, family death, bankruptcy, job loss, pandemic, etc).

Date_____/_____ Event _____ Date _____/_____ Event _____

Date_____/_____ Event _____ Date _____/_____ Event _____

Date_____/_____ Event _____ Date _____/_____ Event _____

FAMILY HISTORY

List any family physical or mental illnesses & age of death

Mother_____

Father _____

Grandparents _____

Siblings _____

Children _____

MEDICATIONS, HERBS, SUPPLEMENTS

List those you are currently taking

Name_____Reason _____How long & Dose_____

Name_____Reason _____How long & Dose_____

Name_____Reason _____How long & Dose_____

Name_____Reason _____How long & Dose_____

Name_____Reason _____How long & Dose_____

LIFESTYLE HABITS

Describe your typical daily diet:

Breakfast _____ Lunch _____

Dinner _____ Snacks _____

Special diet

_____

3 unhealthy foods you eat _____

_____

_____

_____

_____

DO YOU:	YES	NO	
Average 6-8 hours of sleep?	□ Y	□ N	What is the major source of joy in your life
Have a supportive relationship?	□ Y	□ N	_____
Have a history of abuse?	□ Y	□ N	_____
Enjoy your work?	□ Y	□ N	What is the major source of stress in your life
Take vacations?	□ Y	□ N	_____
Spend time outside?	□ Y	□ N	_____
Exercise?	□ Y	□ N	Describe exercise: _____
Watch TV?	□ Y	□ N	How many hours weekly? _____
Read books?	□ Y	□ N	How many hours weekly? _____
Computer games/browsing	□ Y	□ N	How many hours weekly? _____
Spiritual/religious practice?	□ Y	□ N	Describe: _____
Smoke cigarettes?	□ Y	□ N	How much? _____
Smoke cigarettes in the past?	□ Y	□ N	How many years? _____
Eat out often?	□ Y	□ N	How many meals a week? _____
Drink coffee?	□ Y	□ N	How many cups a day? _____
Drink tea?	□ Y	□ N	How many cups a day? _____
Drink soft drinks?	□ Y	□ N	How many a day? _____
Add sugar?	□ Y	□ N	How much? _____
Drink alcohol?	□ Y	□ N	How many drinks a week? _____
Use recreational drugs?	□ Y	□ N	What & how often? _____
Have an addiction?	□ Y	□ N	To what & how long? _____
Been outside the US in the past 12 months?	□ Y	□ N	Where? _____

HOW OFTEN DO YOU CONSUME THE FOLLOWING?

1- Frequently. 2-Occasionally 3- Rarely. 4- Never

Dairy	Juice	Fried Food
Caffeine	Meat	Soda
Sweets	Salt	Water

SKINCARE

Do you have light sensitivity? □ Y □ N

Describe use of sun/weather exposure: _____

Do you wear sunblock? □ Y □ N What SPF strength? _____

Please check items you regularly use

Cleanser	Eye Make-up remover	Soap
Concentrate/ Serum	Mask	Sunscreen
Day Cream	Night Cream	Toner
Eye Cream	Exfoliant/Scrub	Alpha Hydroxy Acid
Benzyl Peroxide	Glycolic Acid	Retin A

Do you use a particular skin-care product line (include facial makeup)? Which products?

How would you describe the condition of your skin?

Have you had facial surgery or cosmetic enhancement? If so, what and when?

What areas of your face are you most concerned about and/or which skin characteristics would you like to change?

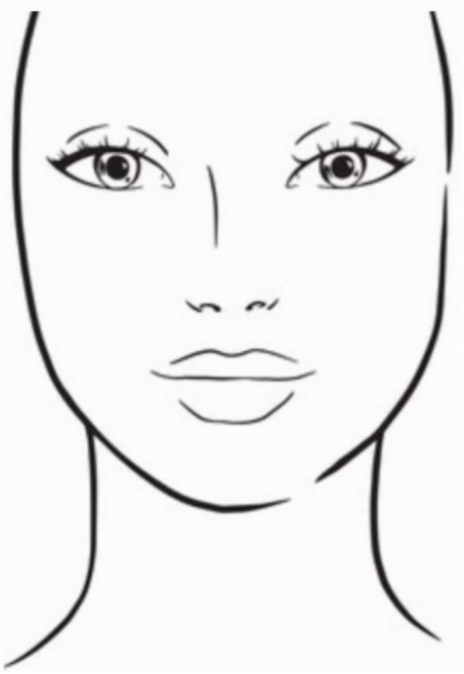
Forehead _____

Eyes _____

Cheeks _____

Jawline _____

Neck _____



Please mark the appropriate squares in the following list of symptoms.

If you have had a symptom in the *past* and do not have it now, check the box like this: ☑

If you are having the symptom *currently*, fill in the box like this: ■

LIVER / GALLBLADDER

☐ Depression / Stress
☐ Headaches / Migraines
☐ Red / Dry / Itchy Eyes
☐ Visual Problems / Blurred Vision
☐ Dizziness
☐ Gall Stones
☐ Feeling of Lump in Throat
☐ Clenching Teeth at Night
☐ Muscle Cramping / Twitching
☐ Neck / Shoulder Pain / Tightness
☐ Seizures / Tremors
☐ Poor Circulation
☐ Soft / Brittle Nails
☐ Bitter Taste in Mouth
☐ PMS / Menstrual Problems
☐ Tendonitis
☐ Pain Below Ribcage
☐ Do you crave: Sour
☐ Tend to be Irritable / Angry

HEART / SMALL INTESTINE

☐ Heart Palpitations
☐ Rapid or Irregular Heartbeat
☐ Chest Pain
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Insomnia / Sleep Problems
☐ Vivid Dreams / Nightmares
☐ Easily Startled
☐ Dark Urine
☐ Red Complexion
☐ Do you crave: Bitter
☐ Anxiety / Nervous or Restless

SPLEEN / STOMACH

☐ Body Heaviness
☐ Hard to Get Up in the Morning
☐ Muscles Often Feel Tired
____ Energy Level: 1-10 (low to high)
☐ Edema (Hands Feet)
☐ Easily Bruising / Bleeding
☐ Bad Breath
☐ Sweetish Taste in Mouth
☐ Lack of Taste
☐ Excess or Low Appetite (circle which)
☐ Excess or Lack of Thirst (circle which)
☐ Nausea / Vomiting
☐ Gas / Belching
☐ Hemorrhoids
☐ Organ Prolapse (i.e. Uterus)
☐ Chronic Loose Stools
☐ Abdominal Pain
☐ Indigestion / Heartburn
☐ Brain Foggy
☐ Mouth Ulcers
☐ Tendency to Gain Weight
☐ Do you crave: Sweet
☐ Over-thinking / Worry

LUNG / LARGE INTESTINE

☐ Bloody Cough
☐ Dry Cough
☐ Chronic Cough
☐ Cough with Sputum
☐ Nasal Discharge
☐ White ☐ Yellow ☐ Green
☐ Post Nasal Drip
☐ Sinus Infection / Congestion
☐ Itchy, Red, or Painful Throat
☐ Dry Mouth / Nose / Throat
☐ Skin Rashes / Hives
☐ Snoring
☐ Shortness of Breath
☐ Allergies / Asthma
☐ Low Immunity
☐ Catch Colds Easily
☐ Bronchitis
☐ Black or Bloody Stools
☐ Constipation
☐ IBS
☐ Diarrhea
☐ Colitis / Spastic Colon
☐ Do you crave: Pungent / Spicy
☐ Grief / Sadness

KIDNEY / URINARY BLADDER

☐ Urinary Problems (i.e. night-time) _____
☐ Bladder Infection
☐ Incontinence
☐ Weakness / Pain in Low Back
☐ Osteoporosis
☐ Feel Cold or Hot Easily (circle which)
☐ Cold Hands / Feet
☐ Low or Excess Sex Drive (circle which)
☐ Dark Circles Under Eyes
☐ Thyroid Problems _____
☐ Poor Memory
☐ Hair Loss / Grey Hair
☐ Hearing Problems / Tinnitus
☐ Cavities
☐ Hot Flashes / Night Sweats
☐ Impotence or Premature Ejaculation (circle which)
☐ Do you crave: Salt
☐ Fear