

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 _____

Home Phone _____ Cell Phone _____ E-mail _____

Emergency Contact: Name _____ Contact Phone: _____

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

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

What is the reason for your visit: _____

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 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) _____

Health Survey

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

Sp/St	Ht/P	Lu/LI	Ki/UB	Liv/GB
<input type="checkbox"/> excessive appetite	<input type="checkbox"/> insomnia	<input type="checkbox"/> cough	<input type="checkbox"/> low back pain	<input type="checkbox"/> eye problems
<input type="checkbox"/> loose stool/diarrhea	<input type="checkbox"/> palpitations	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> knee problems	<input type="checkbox"/> jaundice
<input type="checkbox"/> digestive problems, indigestion	<input type="checkbox"/> cold hands and feet	<input type="checkbox"/> decreased sense of smell	<input type="checkbox"/> hearing impairment	<input type="checkbox"/> difficulty digesting oily foods
<input type="checkbox"/> vomiting	<input type="checkbox"/> nightmares	<input type="checkbox"/> nasal problems	<input type="checkbox"/> ear ringing	<input type="checkbox"/> gall stones
<input type="checkbox"/> belching, burping	<input type="checkbox"/> mentally restless	<input type="checkbox"/> skin problems	<input type="checkbox"/> kidney stones	<input type="checkbox"/> light-colored stool
<input type="checkbox"/> heartburn/reflux	<input type="checkbox"/> laughing for no reason	<input type="checkbox"/> claustrophobia	<input type="checkbox"/> decreased sex drive	<input type="checkbox"/> soft or brittle nails
<input type="checkbox"/> stomach bloating	<input type="checkbox"/> chest pains	<input type="checkbox"/> colitis/diverticulitis	<input type="checkbox"/> hair loss	<input type="checkbox"/> easily angered
<input type="checkbox"/> obsession in work, relationships, etc.	<input type="checkbox"/> poor memory	<input type="checkbox"/> constipation	<input type="checkbox"/> urinary problems	<input type="checkbox"/> difficulty in making decisions
<input type="checkbox"/> lack of appetite	<input type="checkbox"/> sadness	<input type="checkbox"/> blood in stool	<input type="checkbox"/> easily bruised	<input type="checkbox"/> high cholesterol
		<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> dental problems	<input type="checkbox"/> bitter taste
		<input type="checkbox"/> recent use of antibiotics		
<input type="checkbox"/> I usually feel warm	<input type="checkbox"/> I usually feel chilled			

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 your major facial concerns? _____

What are you hoping to accomplish with Acugems Facial Rejuve?

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? _____