PATIENT INFORMATION FORM FOR FACIAL REJUVENATION ACUPUNCTURE AND MICRONEEDLING:

Client Name_____ Date_____
Address:_____
Phone HM:_____ Wk Phone:_____ Cell:_____
Email:_____(information kept private)
Emergency Contact/Phone: _____/_____
Date of Birth____/____/____ Age:_____ Gender: M / F
Occupation:_____ Marital Status:_____ Number of Children_____
How did you hear about us?_____

Because this is a holistic approach to healthcare, it is important for the practitioner to have a complete understanding of the patient; physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible, and print all information. If there is confusion on any area of the form, indicate with a question mark.

COSMETIC FACIAL REJUVENATION ACUPUNCTURE:

What is your daily skin care routine?

_____

_____

What changes in your appearance and skin would you like to see happen?

_____

_____

When did your primary concern begin?_____

What about your skin and appearance is working for you?

_____

_____

For best results a series of 10-15 Facial Rejuvenation Acupuncture treatments 2 x week, and 6

- ☐ Hyperpigmentation
- ☐ Wrinkles
- ☐ Crows Feet
- ☐ Nasal Labial Groove
- ☐ Double Chin
- ☐ Sagging/drooping, where:_____
- ☐ Acne/Breakouts
- ☐ Scarring
- ☐ Couperose/ Rosacea
- ☐ Uneven skin tone
- ☐ Enlarged Pores
- ☐ Dry Skin
- ☐ Oily Skin
- ☐ Other: _____

- ☐ Previous Anti-aging treatments, Types/When:

_____

- ☐ Resurfacing treatments in last month? Type?

_____

- ☐ Botox treatments, When: _____
- ☐ Plastic Surgery, What Kind/When:

_____

- ☐ Use of Retinol/Accutane/Glycolic in last Month
- ☐ High blood pressure, Is it under control of MD?_____
- ☐ Frequent Migraines, How often?, Last occurance?

_____

- ☐ Additional Comments:

_____

Microneedling treatments 1 x month is recommended, followed by monthly and seasonal maintenance treatments. Understand that results vary depending on health history, lifestyle, age and commitment to the frequency of treatments and lifestyle changes, including: diet, exercise, herbal and supplemental intake and home skin care regime.

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MEDICAL HISTORY: (List any major past illnesses, injuries, surgeries with dates)

_____

_____

SIGNIFICANT FAMILY MEDICAL HISTORY: (List briefly and whom)

_____

_____

ALLERGIES OR SENSITIVITIES: (List foods, drugs, medications, metals or skin care products you are allergic or sensitive to (please include reaction):

_____

_____

_____

LIFESTYLE:

Do you follow a regular exercise program? _____ If so, Please describe: _____

_____

Relaxation Practice: _____

Sleep habits/hours of sleep per night:_____do you feel rested?_____

Please describe your average daily diet:

Do you typically eat at least three meals per day? Y/ N If not, how many?_____

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks: _____

Drinks: _____

What particular diet or nutritional program do you generally follow? Example: (macrobiotic, vegetarian, meat & potatoes, low carb, etc.)

_____

Do you generally cook your own meals? _____

Please check any of the following habits that apply. Indicate how much and how often you consume them:

Cigarette smoking:_____ Coffee, tea, cola _____

Alcoholic beverages: _____ Recreational substances _____

MEDICATIONS/SUPPLEMENTS (prescribed and over-the-counter), herbs, vitamins and supplements you are currently taking or taken within last two months:

_____

_____

_____

Please put a check next to conditions you have had

Immunity:
- ☐Fatigue
- ☐Chronic Fatigue
- ☐Slow Healing
- ☐Chronic Colds/Flu
- ☐Chronic infections
- ☐HIV/AIDS
- ☐Other: _____

Head/Eyes/Ears/ Nose/Throat:
- ☐Vision Problems
- ☐Eye Pain/strain/ redness/itching
- ☐Floaters/see spots
- ☐Blurry Vision
- ☐Color Blindness
- ☐Poor Vision
- ☐Night Blindness
- ☐Cataracts
- ☐Glasses/Contacts
- ☐Tearing/Dryness
- ☐Dizziness
- ☐Hearing Problems
- ☐Ear Ringing
- ☐Earaches
- ☐Headaches
- ☐Migraines
- ☐Sinus Problems
- ☐Nose Bleeds
- ☐Facial Pain
- ☐Frequent sore throats
- ☐Teeth Grinding
- ☐TMJ/Jaw Problems
- ☐Seasonal Allergies
- ☐Dental Problems
- ☐Cold Sores
- ☐Dry Mouth
- ☐Bleeding Gums
- ☐Convulsions
- ☐Insomnia
- ☐Other:_____

Respiratory:
- ☐Cough
- ☐Coughing up blood
- ☐Asthma
- ☐Bronchitis
- ☐Pain with Inhalation
- ☐Pneumonia
- ☐Difficult Breathing
- ☐Production of phlegm
- ☐Frequent respiratory infections
- ☐Other:_____

Cardiovascular:
- ☐Hypertension/high blood pressure
- ☐Hypotension/Low Blood pressure Heart
- ☐Fainting
- ☐Cold Hands/Feet
- ☐Swelling of Hands/ Feet
- ☐Poor Circulation
- ☐Chest Pain
- ☐Blood Clots
- ☐Palpitations
- ☐Rapid heart beat
- ☐Irregular heart beat
- ☐Stroke
- ☐Heart Murmurs
- ☐Rheumatic Fever
- ☐Varicose Veins
- ☐Diabetes
- ☐Hypoglycemia
- ☐High Cholesterol
- ☐Other:_____

GastroIntestinal:
- ☐Nausea
- ☐Vomiting
- ☐Reduced Appetite
- ☐Excess Appetite
- ☐Change in Appetite
- ☐Belching
- ☐Acid Reflux
- ☐Ulcers
- ☐Epigastric Pain
- ☐Excessive Gas
- ☐Diarrhea
- ☐Constipation
- ☐Bloating
- ☐Heartburn
- ☐Abdominal Pain
- ☐Weight Loss
- ☐Weight Gain
- ☐Food Cravings
- ☐Excessive Thirst
- ☐Gallbladder Problems
- ☐Liver Disease
- ☐Hepatitis A/B/C
- ☐Hemorrhoids
- ☐Other: _____

GenitoUrinary:
- ☐Kidney Disease
- ☐Painful Urination
- ☐Frequent UTI
- ☐Frequent Urination
- ☐Venereal Disease
- ☐Kidney Stones
- ☐Urination Difficulty
- ☐Blood In Urine
- ☐Night Urination
- ☐Other: _____

MusculoSkeletal:
- ☐Muscle Spasms
- ☐Aches/Pains
- ☐Numbness/Tingling
- ☐Edema
- ☐Excess Sweating
- ☐Cold Hands/Feet
- ☐Cold Body Temp
- ☐Hot Body Temp

Emotional:
- ☐Mood Swings
- ☐Irritability
- ☐Nervousness/ restless
- ☐Stress
- ☐Panic Attacks
- ☐Fear
- ☐Anxiety
- ☐Sadness
- ☐Difficult Concentration
- ☐Forgetfulness
- ☐Other: _____

Skin/Hair:
- ☐Itching
- ☐Hives
- ☐Eczema
- ☐Acne
- ☐Skin Rashes
- ☐Dry Skin
- ☐Hair Loss
- ☐Hair Dry or Brittle
- ☐Premature Greying
- ☐Nails Brittle
- ☐Dandruff
- ☐Other:_____

Comments on Above: _____

WOMEN'S HEALTH:
First day of last menses: _____ Age of first menses: _____
Typical duration of bleeding: _____ Length of menstrual cycle: _____ Is it regular?: _____ If not, explain: _____
Heavy bleeding or light flow? _____ Clotting? (size, quantity) _____
Color of blood (red, dark red, purple, brown, blackish): _____
Discomfort or pain during periods? _____ Stage of cycle?_____
breast tenderness during menses or ovulation? _____
Premenstrual symptoms? please specify: _____
Spotting between periods? _____
Have been diagnosed with: Fibroids? _____ Cysts? _____ Cervical dysplasia? _____
Pelvic inflammatory disease? _____ Unusual discharge? _____
Type of birth control? _____ How long? _____
Total # of Pregnancies: _____ Number of births:_____ Premature births: _____
Miscarriages: _____ Abortions: _____ Are you pregnant now? Yes / No / Maybe
Menopause?: _____ Age of Menopause: _____ Hot flashes? _____
Other Symptoms?: _____
Hormone replacement therapy? _____ Other treatments? _____
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Consent For Treatment - Facial Rejuvenation Acupuncture and Microneedling

I freely choose to undergo Facial Rejuvenation Acupuncture treatments and/or Microneedling with Lisa Ledbetter (practitioner name), knowing that there are no guaranteed results, and I am free to stop treatment at any time. The goal of these treatments, is improvement - not perfection. I understand my results might not be perfect, and the number of treatments necessary may vary. There may be more treatments necessary than I anticipated. There is no guarantee that expected or anticipated results will be achieved. I understand that compliance with recommended Microneedling aftercare guidelines are crucial for healing and prevention of scarring or skin textural changes.

An acupuncture facial treatment involves the insertion of acupuncture needles into fine lines and wrinkles on the face and neck in order to reduce the visible signs of aging. In Chinese medicine, the meridians or pathways of Qi (energy) flow throughout the entire body from the soles of the feet up to the face and head; consequently, a facial acupuncture treatment addresses the entire body constitutionally, and is not merely "cosmetic."

An acupuncture facial involves the patient in an organic, gradual process, that is customized for each individual. It is no way analogous to, or a substitute for, a surgical "face lift". A treatment session may confine itself solely to facial acupuncture, or it may be used in conjunction with other procedures.

I understand that while acupuncture and microneedling are generally safe methods of treatment, certain adverse effects may result from treatment. These may be, but are not limited to local bruising (hematomas), puffiness, redness, bleeding, temporary pain or discomfort at the site of the needles during or after the treatment, and in more rare circumstances there are the risks of fainting, infection, damage to blood vessels or nerves. In some circumstances, local allergies to topical preparations have been

reported. Systemic reactions which are more serious may occur with herbs used during an acupuncture facial. Allergic reactions may require additional treatment.

With microneedling there may be redness, discomfort and/or swelling, or the sensation of having a sunburn at the area of treatment for a few to several hours after treatment. Additionally, redness may be present for 2-3 days after treatment. There may be an increase or decrease in pigmentation and can take 4-6 months or more to resolve. Loss of pigmented lesions such as freckles may give the appearance of loss of pigment. Small areas of scabbing may occur 2-3 days following the treatment. Infection is possible if proper aftercare guidelines are not followed.

I understand the methods of treatment in the scope of Chinese medicine may include but are not limited to acupuncture, microneedling, cupping, moxibustion (applying heat to acupuncture points of the body), electro-stimulation acupuncture, Tui-Na (Chinese massage), and herbal medicine.

Although noticeable results may be obtained with a single MicroNeedling or Facial Acupuncture treatment; the greatest improvement will be seen after a series of four to six consecutive monthly Microneedling procedures, and ten to fifteen Facial Acupuncture sessions twice per week, or a combination of the two.

I understand the acupuncturist is not providing Western medical care, and I should look to my Western primary care physician (MD) for those services and routine checkups.

I understand I must inform my acupuncturist if I am **Pregnant**, have an **acute cold or flu**, an **acute herpes outbreak**, an **acute allergic reaction**, an **active inflammatory skin condition**, am **using accutane or any related acne medication, high blood pressure, diabetes, severe migraines**, am **HIV positive or have AIDS, cancer, or hepatitis**, as these may have additional risks or contraindications with facial acupuncture and microneedling.

I understand all fees for services are due at the time of service, and I will be charged the full fee for appointments that are cancelled with less than 24 hours notice.

I have read, or have had read to me, and completely understand the risks and benefits of acupuncture treatment, and have had an opportunity to ask questions. I intend this consent form to cover the entire coarse of treatment for my present treatment and for any future condition(s) for which I seek treatment.

Printed Name:_____

Signature:_____

Date: _____