AcuMeridian Wellness, LLC
420 Rt 34, Suite 317, Colts Neck, NJ 07722 *(732)858-1322* *http://www.acumeridianwellness.com*

Facial Rejuvenation Acupuncture Registration

This questionnaire provides valuable information to help us understand the underlying causes of your health concerns. All information contained in this form is strictly confidential and will become part of your medical record on file.

PATIENT NAME: _____ **Date:** _____

SKIN CARE HISTORY

1. Please check any of the following which are of most concern to you:

- ☐ Bags/swelling under eyes
- ☐ Wrinkles
  - ☐ Nasolabial (nose to mouth)
  - ☐ Eyes (crow's-feet)
  - ☐ Lips
  - ☐ Other: _____
- ☐ Lusterless skin
- ☐ Sagging face
- ☐ Droopy eyelids
- ☐ Double chin
- ☐ Acne
- ☐ Rosacea
- ☐ Oily skin
- ☐ Broken capillaries
- ☐ Vertical creases / furrows
- ☐ Premature graying of hair
- ☐ Sun damage
- ☐ Acne scarring
- ☐ Large pores
- ☐ Dry skin
- ☐ Protruding temporal veins

☐ Other skin conditions/issues:

_____

2. Do you wear makeup daily? ☐ Yes ☐ No Do you wear sunscreen daily? ☐ Yes ☐ No

3. Please describe your current skin care regimen and products that you use. (Toner, astringent, exfoliation, masks, etc.): _____

_____

4. Please describe any skin sensitivities or allergies:_____

_____

5. What improvements would you like to see? _____

_____

6. Do you go to tanning booths? ☐ Yes ☐ No

7. Do you participate in vigorous aerobic activity or sport? ☐ Yes ☐ No

8. Do you get facial waxing/electrolysis or use depilatories? ☐ Yes ☐ No If yes, wait 5 days between treatments

9. Please check all procedures you have had or are currently undergoing.

☐ Botox injections	Date(s): _____	☐ Laser procedures	Date(s): _____
☐ Collagen injections	Date(s): _____	☐ Threading (Lift)	Date(s): _____
☐ Restalyne	Date(s): _____	☐ Rhytidectomy	Date(s): _____
☐ Silicon injections	Date(s): _____	☐ Blepharoplasty	Date(s): _____
☐ Mesotherapy	Date(s): _____	☐ Brow or Coronal lift	Date(s): _____
☐ Microdermabrasion	Date(s): _____	☐ Other: _____	Date(s): _____
☐ Chemical peels	Date(s): _____		

AcuMeridian Wellness, LLC
420 Rt 34, Suite317, Colts Neck, NJ 07722 *(732)858-1322* *http://www.acumeridianwellness.com*

Facial Rejuvenation Acupuncture - Initial Visit

Name Last _____First _____ Middle _____ SS# ___ /__ /____

Date of Birth_____ /_____ /_____ **Gender** F ____M _____ **Email**_____

Address _____City _____

State_____ Zip Code_____

Telephone: Home (_____) _____ - _____ Work (_____) _____ - _____ Ext _____

Marital Status: S ☐ M ☐ D ☐ Other:_____ **Occupation** _____

Height _____ **Weight** _____ **Blood Pressure**_____**Pulse**_____

Have you ever had an acupuncture facial? Y ☐ N ☐

Have you been treated by Acupuncture or Oriental medicine before? Y ☐ N ☐

Name of your physician _____Phone _____

In an Emergency Notify: Name _____ Relationship to patient _____

Home Phone (_____)_____ - _____ Cell Phone (_____) _____ - _____Work Phone (_____) _____ - _____

FINANCIAL AGREEMENT

Payment for Clinic Services Rendered: Payment is **due at the time of service** and may be paid by cash, check or all major credit cards. Any checks returned due to insufficient funds will be charged an additional $30.

Cancellation Policy:
Please be respectful of the time set aside for your treatment. All scheduled appointments require a 24 hour cancellation notice or the patient will be charged for a FULL office visit fee.

Herbal Prescriptions:
I understand that **all herb sales are final** as herbal prescriptions are intended only for the patient for whom they have been prescribed.

By signing this agreement, I am acknowledging that I have read the above financial policies and will be responsible for all charges stated above.

Patient's Signature _____ Date_____

MEDICAL HISTORY
Past and Present Illnesses(with dates):

_____

Surgeries(with dates):

_____

Significant Trauma (Auto accidents, falls, etc., with dates) :

_____

Do you have, or have you ever had, any **Infectious Diseases**? Yes ☐ No ☐ If so, please describe:

_____

CURRENT MEDICATIONS: (prescription and over-the-counter drugs, vitamins, herbs, etc.)

_____

_____

ALLERGIES:

_____

Do you bruise or bleed easily? Yes ☐ No ☐

PERSONAL HISTORY

Hobbies & Recreational Habits _____

Do you have a regular exercise program? Yes ☐ No ☐ If so, please describe:

_____

Smoking? Yes ☐ No ☐ Alcohol? Yes ☐ No ☐

PLEAE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST SIX MONTHS)

☐ Fevers ☐ Chills ☐ Poor Appetite ☐ Night Sweats ☐ Day Sweating ☐ Bleeding or Bruising

☐ Fatigue ☐ Sudden energy drops? What time of Day? _____

☐ Poor Sleep/Insomnia ☐ Dream Disturbed Sleep ☐ Emotional Changes ☐ Mania

☐ Weight Loss ☐ Weight Gain ☐ Strong thirst for Hot or Cold drinks?

☐ Joint Pain ☐ Localized Weakness ☐ Poor Balance

NEUROPSYCHOLOGICAL

☐ Seizures ☐ Areas of Numbness ☐ Anxiety ☐ Concussion ☐ Lack of Coordination ☐ Poor Memory

☐ Dizziness ☐ Loss of Balance ☐ Easily Angered ☐ Headaches ☐ Fainting ☐ Depression/Bipolar

☐ Migraines ☐ Disorientation ☐ Mania ☐ Easily Susceptible to Stress

PREGNANCY & GYNECOLOGY

☐ Period between Menses ☐ Birth Control ☐ Duration of Menses _____ ☐ Painful Periods ☐ Irregular Periods

☐ Heavy or ☐ Light Periods ☐ Clots ☐ Vaginal Discharge ☐ Breast Lumps ☐ PMS ☐ Currently Pregnant

First Date of Last Menstrual Cycle _____/_____/_____

CARDIOVASCULAR

☐ High blood pressure ☐ Dizziness ☐ Swelling of Hands ☐ Blood Clots ☐ Irregular heartbeat ☐ Fainting

☐ Difficulty in Breathing ☐ Palpitations ☐ Low blood pressure ☐ Cold Sweats ☐ Cold Hands/Feet

☐ Chest pain ☐ Swelling of Feet

RESPIRATORY

☐ Cough ☐ Pain w/ Deep Breaths ☐ Difficulty in Breathing ☐ Asthma ☐ Bronchitis ☐ Shortness of Breath

GASTROINTESTINAL

☐ Nausea ☐ Abdominal Pain/ Cramps ☐ Digestive Disorders ☐ Vomiting ☐ Constipation ☐ Indigestion

GENITO-URINARY

☐ Pain on Urination ☐ Frequent Urination ☐ Waking up to Urinate ☐ Unable to Hold Urine