Facial Acupuncture Intake Form
Debra Gorman Acupuncture – Optimal Health Center of Santa Rosa

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 don't feel certain questions pertain to your present condition. Thank you. **Today's Date_____**

Personal Information

Name_____ Age _____ Date of Birth_____

Marital Status_____ Gender _____ Height_____ Weight _____

Occupation _____ Employer _____

Address_____ Drivers License Number _____

City_____State_____ Zip_____

Home Phone_____ Work Phone _____ Mobile _____

Email _____ Fax _____

Emergency Contact: Name_____ Phone _____

Whom should we thank for referring you? _____

Have you had acupuncture before? ☐Yes ☐No Have you used Chinese Herbal Medicine? ☐Yes ☐No

Have you had facial acupuncture before? ☐Yes ☐No Do you bruise easily? ☐Yes ☐No

What medications are you taking? _____

What vitamins and supplements are you taking? _____

For what condition(s)? _____

What is your blood type? _____

Please indicate if any of the following pertain to you.
Indicating "yes" does not make you ineligible for treatment, however, it may restrict some of our treatment modalities.

☐Herpes	☐HIV/AIDs	☐High Blood Pressure	☐Seizures	☐Pacemaker	☐Blood Thinners
☐Migraines	☐ Hemophilia	☐ Acute cold/flu	☐ Allergy	☐Any pituitary disorder such as a tumor	
☐Asthma	☐Cancer	☐Hepatitis A/B/C	☐Emphysema	☐Lyme Disease	☐Pregnancy
☐Polio	☐Diabetes	☐Multiple Sclerosis	☐Tuberculosis	☐Heart Disease	☐Lymph nodes removed
☐Mitral valve	☐Scarlet Fever	☐Rheumatic Fever	☐Birth Trauma	☐Varicose Veins	☐Latex Allergies

Insurance

Insurance Company _____ Phone _____

Policy Number _____ Deductible _____ % of Coverage _____

Current Condition

Reason for todays visit _____

When did it start? _____

How did it start? _____

What makes it better? _____
(heat, cold, rest, activity, time of day, emotions, food?)

What makes it worse ? _____

Does it bother your: Sleep? Work? Activities of Daily Living? _____

Are you under the care of a physician for this or any other condition? _____

Physician's name _____ Physician's phone _____

Health Concerns

Including your reason for being here today, what other concerns do you have? Please list in order of importance.

	Severe	Moderate	Slight
1. _____	☐	☐	☐
2. _____	☐	☐	☐
3. _____	☐	☐	☐
4. _____	☐	☐	☐
5. _____	☐	☐	☐
6. _____	☐	☐	☐
7. _____	☐	☐	☐

Health History

Please check any conditions you have had or currently have:

☐ Cancer	☐ Diabetes	☐ Heart Disease	☐ Stoke/TIA	☐ Epilepsy/Seizure	☐ Sexually Transmitted Disease
☐ HIV/AIDS	☐ Herpes	☐ Shingles	☐ Syphilis	☐ Addiction	☐ Chemical Dependency
☐ Chlamydia	☐ Hepatitis	☐ Jaundice	☐ Gonorrhea	☐ Substance Abuse	☐ Hashimoto's Thyroiditis
☐ Pancreatitis	☐ Choleocystitis	☐ Goiter	☐ Gout	☐ Hyperthyroid	☐ Hypothyroid
☐ Alcoholism	☐ Low BP	☐ High BP	☐ Hypertension	☐ Obesity	☐ Metabolic Syndrome
☐ Meningitis	☐ Measles	☐ Mumps	☐ Chicken Pox	☐ Polio	☐ Mononucleosis
☐ Strep Throat	☐ Anorexia	☐ Bulimia	☐ Depression	☐ Kidney Disease	☐ Rheumatic Fever
☐ Mental Illness	☐ PTSD	☐ Bi Polar	☐ Anxiety	☐ Eating Disorder	☐ Arteriosclerosis
☐ Anemia	☐ Arthritis	☐ Asthma	☐ Allergies	☐ Suicide Attempt	☐ Atherosclerosis
☐ IBS	☐ IBD	☐ Ulcers	☐ Candida	☐ Bleeding Tendency	☐ Multiple Sclerosis/MS
☐ Emphysema	☐ COPD	☐ Pneumonia	☐ Fibromyalgia	☐ Autoimmune Disease	☐ Chronic Fatigue Syndrome
☐ Cystic Breasts	☐ Hernia	☐ Bronchitis	☐ Osteoporosis	☐ Whooping Cough	☐ Uterine Fibroids
☐ Parkinson's	☐ Alzheimer's	☐ Dementia	☐ Appendicitis	☐ Prostate Problems	☐ Organ Transplant

Surgery (please include dates and any complications)

_____
_____
_____
_____

Motor Vehicle Accidents (please include dates and injuries)

_____
_____
_____
_____

Falls/Other Physical Trauma (please include dates and any complications)

_____
_____
_____
_____

Hospital Stays:

_____
_____
_____
_____

Allergies:
Medications _____
Food _____-___
Chemicals _____
Seasonal _____
Environmental _____

Recent Tests (dates and results)

Physical Exam _____
Blood _____
Cholesterol _____
HIV/STD _____
Ob/Gyno _____
Mammogram _____
Pap _____
Prostate _____
Colonoscopy _____

Medications

Type	Dose/Duration	Reason	Side Effects

Supplements

Type	Dose/Duration	Reason

Family Health History

Family Member	Alive	Deceased	Present Health Condition
Father			
Mother			
Spouse			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandmother			
Brother(s)			
Sister (s)			

Lifestyle

Exercise: (type, duration, frequency)

_____

_____

_____

Habits:

Coffee	☐never	☐rarely	☐__x/week	☐__x/day	Recreational Drugs	☐never	☐rarely	☐__x/week	☐__x/day
Tea	☐never	☐rarely	☐__x/week	☐__x/day	Alcohol	☐never	☐rarely	☐__x/week	☐__x/day
Soda	☐never	☐rarely	☐__x/week	☐__x/day	Diet Soda	☐never	☐rarely	☐__x/week	☐__x/day
Sugar	☐never	☐rarely	☐__x/week	☐__x/day	Cigarettes	☐never	☐rarely	☐__x/week	☐__x/day

How many servings do you consume per day or per week?

Chicken/Pork	☐never	☐rarely	☐____x/week	☐____x/day	Food Cravings:
Fatty Fish	☐never	☐rarely	☐____x/week	☐____x/day	
Sugar/sweets	☐never	☐rarely	☐____x/week	☐____x/day	
Dairy	☐never	☐rarely	☐____x/week	☐____x/day	
Legumes	☐never	☐rarely	☐____x/week	☐____x/day	
Nuts and seeds	☐never	☐rarely	☐____x/week	☐____x/day	Food Intolerances:
Fermented foods	☐never	☐rarely	☐____x/week	☐____x/day	
Fresh Veggies	☐never	☐rarely	☐____x/week	☐____x/day	
Fresh Fruit	☐never	☐rarely	☐____x/week	☐____x/day	

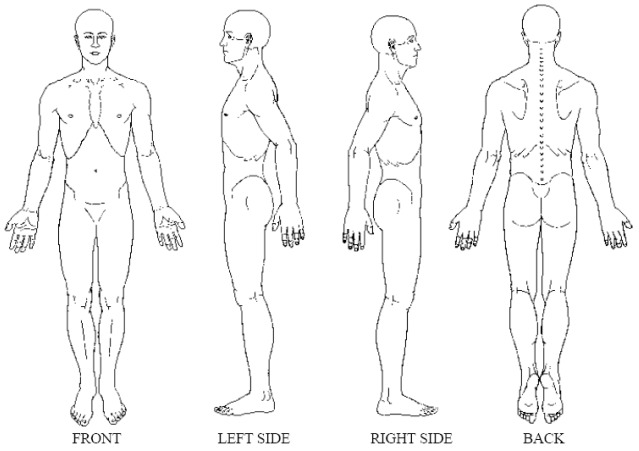
Diet: (please describe your current diet, including a typical breakfast, lunch, dinner snack, cravings and goals)

Symptom Overview by System

Please circle all symptoms that you are CURRENTLY experiencing (Acute or Chronic) and/or experience FREQUENTLY.
A = Acute (under 3 months) C = Chronic (over 3 months—experience at some point most days) F = Experience frequently (on & off)

MUSCULOSKELETAL

A	C	F	Joint clicking	A	C	F	Limited range of motion	A	C	F	Stiffness
A	C	F	Spasms	A	C	F	Cramps	A	C	F	Swelling
A	C	F	Pain: Full body	A	C	F	Pain: Facial (e.g. jaw)	A	C	F	Pain: Neck
A	C	F	Pain: Upper Back	A	C	F	Pain: Mid Back	A	C	F	Pain: Low Back
A	C	F	Pain: Shoulder	A	C	F	Pain: Elbow	A	C	F	Pain: Wrist
A	C	F	Pain: Hand	A	C	F	Pain: Hip	A	C	F	Pain: Knee
A	C	F	Pain: Ankle	A	C	F	Pain: Foot	A	C	F	Weakness



Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition.

Key:
→ Radiating Pain
X Spasm
Z Tenderness
V Burning
* Numbness/Tingling
o Ache/Pain

HEAD, EYES, EARS, NOSE & THROAT

A	C	F	Loss of vision	A	C	F	Dry mouth	A	C	F	Loss of hearing, deafness
A	C	F	Itchy eyes	A	C	F	Excessive salivation	A	C	F	Tinnitus
A	C	F	Blurry vision	A	C	F	Bland taste in mouth	A	C	F	Ear discharge
A	C	F	Near sighted	A	C	F	Sour taste in mouth	A	C	F	Ear itching
A	C	F	Eye pain	A	C	F	Bitter taste in mouth	A	C	F	Problems with balance (vertigo)
A	C	F	Eye discharge	A	C	F	Sweet taste in mouth				
A	C	F	Tearing	A	C	F	Bad breath	A	C	F	Impaired sense of smell
A	C	F	Eye dryness	A	C	F	Mouth sores	A	C	F	Allergic Rhinitis
A	C	F	Red eyes	A	C	F	Sore throat	A	C	F	Nasal congestions
A	C	F	Far sighted	A	C	F	No thirst	A	C	F	Nose bleeds
A	C	F	Astigmatism	A	C	F	Excessive thirst	A	C	F	Sinus pain, pressure
A	C	F	Spots before your eyes	A	C	F	Thirst, no desire to drink	A	C	F	Sinusitis

DIGESTIVE

BOWEL MOVEMENT: HOW MANY TIMES PER DAY/WEEK? _____

A	C	F	Low/no appetite	A	C	F	Constipation	A	C	F	Indigestion
A	C	F	Big/excessive appetite	A	C	F	Loose stools/Diarrhea	A	C	F	Acid regurgitation/ GERD
A	C	F	Abdominal distention	A	C	F	Alternating constipation/diarrhea	A	C	F	Heartburn
A	C	F	Gurgling/rumbling in abdomen	A	C	F	Gas	A	C	F	Bloating
A	C	F	Pain/discomfort around ribs	A	C	F	Rectal bleeding	A	C	F	Nausea
A	C	F	Abdominal pain, cramps	A	C	F	Hemorrhoids	A	C	F	Vomiting
A	C	F	Abdominal mass	A	C	F	Hiccups	A	C	F	Eating disorder
A	C	F	Jaundice (yellow skin &/or eyes)	A	C	F	Belching/Burping	A	C	F	Tired after eating
A	C	F	Ulcer	A	C	F	Hernia	A	C	F	Esophageal spasm

RESPIRATORY

A C F Chest pain
A C F Cough
A C F Sputum production
A C F Wheezing
A C F Chest tightness
A C F Coughing up blood (hemoptysis)
A C F Voice changes
A C F Bluish discoloration of skin
A C F Shortness of breath (dypsnea)
A C F Hoarseness

CARDIOVASCULAR

A C F Chest pain &/or pressure
A C F Edema
A C F Swelling of the ankles &/or legs
A C F Missed heart beat
A C F Changes in skin temperature
A C F Fainting (syncope)
A C F Racing heart
A C F Fatigue
A C F Changes in skin color
A C F Sweating with little/no exertion
A C F Palpitations

UROGENITAL

URINATION:
A C F Painful urination (dysurea)
A C F Difficulty with urine flow
A C F Dribbling after urination
A C F Incontinence

HOW MANY TIMES PER DAY? _____
A C F Blood in urine
A C F Dark urine
A C F Urinary tract infection (UTI)
A C F STD

HOW MANY TIMES PER NIGHT? _____
A C F Frequent urination
A C F Abundant urination
A C F Excessive urination at night
A C F Scanty urine

NEUROLOGICAL

A C F Difficulty concentrating
A C F Cloudy thinking
A C F Confusion
A C F Loss of memory
A C F Severe forgetfulness
A C F Numbness and/or tingling
A C F Changes in consciousness
A C F Loss of consciousness
A C F Dizziness
A C F Headache
A C F Visual disturbance
A C F Post shingles pain
A C F Problems coordinating movements
A C F Gait disturbance
A C F Dysphasia (impaired speech)
A C F Paralysis
A C F Tremor
A C F Weakness

INTEGUMENTARY (SKIN/HAIR/NAILS)

A C F Rash and/or skin lesion
A C F Changes in skin color
A C F Itching (pruritus)
A C F Wounds that will NOT heal
A C F Acne
A C F Changes in hair
A C F Hair loss
A C F Changes in nails
A C F Dry skin/nail/hair
A C F Rosacea
A C F Never sweat
A C F Night sweats
A C F Sweat with no exercise
A C F Oily skin/nail/hair

SLEEP

Number of hours of sleep/night_____ Bedtime _____ Wake time _____

A C F Insomnia
A C F Difficulty falling asleep
A C F Wake regularly @ _____ AM/PM
A C F Dream disturbed sleep
A C F Nightmares
A C F Wake up & cannot fall back asleep
A C F Restless, toss and turn

EMOTIONAL/ PSYCHOLOGICAL/MENTAL

A C F Frequent crying
A C F Grief
A C F Melancholy
A C F Depression
A C F Feeling overwhelmed
A C F Extreme lack of emotion
A C F Anger
A C F Mania
A C F Anxiety
A C F Restlessness
A C F Stress
A C F Extreme mood swings
A C F Fear
A C F Easily startled
A C F Worry
A C F Overthinking
A C F Obsessive thinking
A C F Difficulty making decisions

MISCELLANEOUS

A C F Extremely low energy/fatigue
A C F Frequent colds
A C F Chills and/or fever
A C F Feel cold
A C F Feel hot
A C F Cold hands and feet

FOR WOMEN ONLY

Are you still menstruating? ☐ YES ☐ NO
Age of first period _____ Date of last period _____
Length of cycle_____ # days bleeding _____

	Color of flow (pale, bright, dark, brown)	Amount of flow (light, heavy, clots)	# of tampons you use/day (super, regular, liner)	pain/cramping (mild, moderate, severe)
Day 1				
Day 2				
Day 3				
Day 4				
Day 5				
Additional days				

Are you pregnant OR trying to become pregnant? ☐ YES ☐ NO
Number of pregnancies _____ Live births_____ Miscarriages _____ Abortions _____

A C F Irregular menstruation	A C F Abnormal vaginal bleeding	A C F No menses (ammenorhea)
A C F Difficult menstruation	A C F Vaginal discharge	A C F Fertility concerns
A C F Pain with menses (dysmenorrhea)	A C F Fibrocystic breasts	A C F Menopausal symptoms
A C F Pain during or after sex	A C F Sexual dysfunction	A C F Low libido
A C F Pelvic pain	A C F Changes in hair distribution	A C F Excessive sex drive

PMS Symptoms

A C F Swollen breasts	A C F Increased appetite	A C F Constipation
A C F Headache	A C F Decreased appetite	A C F Diarrhea
A C F Mood swings	A C F Insomnia	
A C F Water retention		

Have you ever been diagnosed with?

☐ Uterine Fibroids (myomas)	☐ PID	☐ Ovarian cysts
☐ Endometriosis	☐ STD	☐ Polycystic ovarian syndrome (PCOC)

FOR MEN ONLY

A C F Fertility concerns	A C F Prostate problems
A C F Sexual dysfunction	A C F Unusual discharge
A C F Low libido	A C F Excessive sex drive

Please use this space to list any other symptoms or include any other concerns you may have about your health.

Informed Consent for Facial Rejuvenation Acupuncture

Introduction: A facial acupuncture 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 Oriental 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." Facial acupuncture involves the patient in an organic and gradual process that is customized for each individual. It is no way analogous to, or a substitute for, a surgical "face lift."

Benefits: Facial rejuvenation acupuncture can increase facial tone, decrease puffiness around the eyes, as well as bring more firmness to sagging skin, enhance the radiance of the complexion and flesh out sunken areas. Customarily, fine wrinkles will disappear and deeper ones will be reduced. As this treatment is not merely confined to the face, but incorporates the entire body and constitutional issues of health.

Alternate Treatment: Improvement of sagging skin, wrinkles and fatty deposits may be attempted by other treatments or surgery such as a surgical facelift, chemical face peels, or liposuction. Risk and potential complications are associated with these alternative forms of treatment.

Risks of Facial Rejuvenation Acupuncture: Every procedure involves a certain amount of risk and it is important that you understand the risks involved with facial rejuvenation acupuncture. An individual's choice to undergo facial rejuvenation acupuncture is based upon the comparison of the risk to potential benefit. Although the majority of patients do not experience the following complications, you should discuss each of them with your acupuncturist to make sure you understand the risks, potential complications, and consequences of facial rejuvenation acupuncture.

• *Bleeding:* It is possible, though very unusual, that you may have problems with bleeding during facial acupuncture. Should post-acupuncture bleeding occur, it will usually only consist of a few drops. Accumulations of blood under the skin may cause a bruise (hematoma), which will resolve itself.

• *Infection:* Infection is extremely unusual after facial acupuncture. Should an infection occur, additional treatment may be necessary.

• *Damage to Deeper Structures:* Deeper structures such as blood vessels and muscles are rarely damaged during the course of facial rejuvenation acupuncture treatment. If this does occur, the injury may be temporary or permanent.

• *Asymmetry:* The human face is normally asymmetrical. Thus, there can be a variation from one side to the other in the results attained from a facial acupuncture treatment.

• *Bruising and Puffiness:* There is a possibility of bruising (hematoma), puffiness, blood, tingling, itching, warmth, pain or other symptoms at the site of the needle.

• *Nerve Injury:* Injuries to the motor or sensory nerves rarely result from facial acupuncture treatments. Nerve injuries may cause temporary or permanent loss of facial movements and feeling. Such injuries may improve over time. Injury to sensory nerves of the face, neck and ear regions may cause temporary or more rarely permanent numbness. Painful nerve scarring is very rare.

• *Needle Shock:* Needle shock is a rare complication after a facial acupuncture treatment.

• *Unsatisfactory Result:* There is the possibility of a poor result from facial rejuvenation acupuncture. You may be disappointed with the results. The practice of acupuncture is not an exact science. Although good results are expected, there is no guarantee or warranty, either expressed or implied, on the results that may be obtained.

• *Allergic Reactions:* In rare cases, local allergies to topical preparations have been reported. Allergic reactions may require additional treatment.

• *Delayed Healing:* Delayed wound healing or wound disruption is a rare complication experienced by patients in the aftermath of facial acupuncture. There is a greater risk for smokers, who frequently have dry, sagging skin, which does not heal as readily as that of non-smokers.

Long Term Effects: Subsequent alterations in facial appearance may occur as the result of the normal process of aging, weight loss or gain, sun exposure, or other circumstances not related to facial rejuvenation acupuncture. Facial acupuncture does not arrest the aging process or produce permanent tightening of the face and neck. Future facial acupuncture maintenance treatments, or other treatments, may be necessary to maintain the results of facial rejuvenation acupuncture.

Disclaimer: Informed consent documents are used to communicate information about the proposed procedure along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your acupuncturist may provide you with additional or different information that is based upon all the facts in your particular case and the present state of knowledge within the field of acupuncture. Informed consent documents are not intended to define or serve as the standard of acupuncture. Standards of acupuncture are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve. It is important that you read the above information carefully and have all of your questions answered before signing the following consent.

CONSENT FOR FACIAL ACUPUNCTURE PROCEDURE OR TREATMENT

1. I, _____, hereby authorize licensed acupuncturist to perform facial rejuvenation acupuncture. I have received the INFORMED CONSENT FOR FACIAL REJUVENATION ACUPUNCTURE.

2. I recognize that during the course of the facial rejuvenation acupuncture treatment, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the acupuncturist to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my acupuncturist at the time the procedure is begun.

3. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

4. It has been explained to me in a way that I understand:
   a. The above treatment or exposure to be undertaken
   b. That there may be alternative procedures or methods of treatment
   c. That there are risks to the procedure or treatment proposed

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS. I AM SATISFIED WITH THE EXPLANATION.

_____	_____	_____
Signature	Printed name	Date