Winchester Center for Acupuncture & Health

600 Main Street, #4 Winchester MA 01890 781.729.8880

FACIAL REJUVENATION HEALTH HISTORY QUESTIONAIRE

Please fill out this questionnaire to the best of your ability. Your answers will assist us in providing you with a complete evaluation. All answers will be held in absolute confidentiality. If you have any questions, please ask. If there is anything you wish to add that is not included in this questionnaire, please note it in the "Comments" section at the end. Thank you.

Name_____Date_____

Street_____City_____State/Zip_____

Home Phone_____Work Phone_____Cell Phone_____

Email_____

Age_____Date of Birth_____Occupation _____

Relationship/Marital Status_____

Emergency Contact _____Relation to You_____

Emergency Contact telephone_____

Referred by_____May we thank this person?_____

Facial Evaluation

Have you had or used any of the following? Please check all that apply:

□ Microcurrent facial treatments * When?_____

□ Retin A or Renova * When, and for how long?_____

□ Botox or fillers * Dates, and describe_____

□ Plastic surgery * Dates, and describe_____

□ Reaction to a skin product * Describe_____

Please list the skin care products that you currently use_____

_____

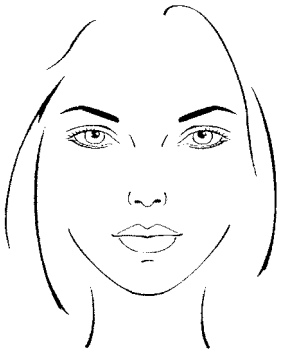
_____

Do you regularly wear facial sunscreen? □ Yes □ No

What do you hope to accomplish with Microcurrent treatments?_____

_____

Please indicate the areas of your main concern on the face below:



Please check any of the conditions that you have now or have had in the past:

□ Acne	□ Eczema	□ Itching	□ Psoriasis
□ Rashes	□ Rosacea	□ Skin Allergies	□ Skin Cancer

Health Evaluation

Are you pregnant or trying to conceive? □ Yes □ No

Do you have a pacemaker? □ Yes □ No

Do you have any metal implants □ Yes □ No Where?_____

Are you taking a blood thinner (Heparin, Coumadin)? □ Yes □ No

Please list any Hospitalizations or Surgeries, including dates:_____

_____

_____

_____

_____

Please list any Significant Trauma (accidents, falls, head injuries etc., including dates):_____

_____

_____

_____

Please check any of the conditions that apply to you:

□ Allergies	□ Colitis / diverticulitis	□ Irregular heart beat
□ Anxiety	□ Concussion	□ Migraines
□ Areas of numbness	□ Diabetes	□ Muscle pain / spasm
□ Asthma	□ Difficulty breathing	□ Palpitations
□ Back / neck pain	□ Digestive problems	□ Ringing in ears
□ Bleed or bruise easily	□ Dizziness / loss of balance	□ Seizures
□ Blood clots	□ Eye pain or disease	□ Sinus / nasal problems
□ Cancer	□ Facial pain	□ Sores on lips or tongue
□ Chest pain / tightness	□ Heart disease	□ Stroke
□ Chills / fever	□ Hepatitis	□ Thyroid condition
□ Chronic fatigue	□ High / low blood pressure	□ TMJ
□ Clotting disorders	□ Insomnia	□ Tuberculosis

If you checked any of the above, please describe:_____

_____

_____

Please list any Medications & Vitamins that you take (continue on back if necessary)

Name	Dosage/Frequency	Length of time taken	Reason for taking

Do you have a regular exercise program □ Yes □ No If yes, please describe_____

_____

Do you smoke?_____How much/day?_____How long?_____

How many cups of caffeinated coffee, tea, or soda do you drink per week?_____

How many 8 oz. glasses of water do you drink per day?_____

How many alcoholic beverages do you drink per week?_____

Comments:_____

_____