NEW PATIENT COSMETIC ACUPUNCTURE INTAKE FORM

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone #: _____ Email: _____

Emergency Contact: _____ Phone #:_____ Relation: _____

Have you ever received Acupuncture before? Yes / No

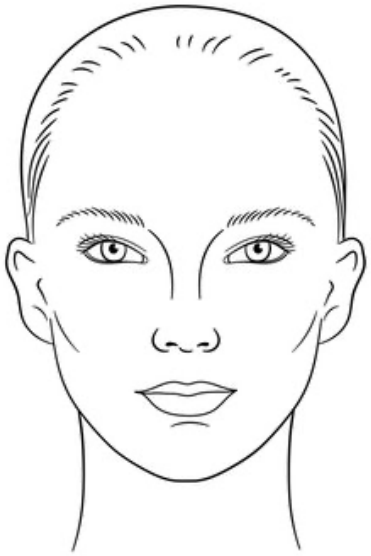
List any medications/supplements you are currently taking: _____

_____

List any known allergies: _____

What areas of concern do you have regarding your skin? (mark areas that concerns apply)

- ☐ Acne/breakouts
- ☐ Redness
- ☐ Uneven skin tone
- ☐ Blackheads/whiteheads
- ☐ Large pores
- ☐ Wrinkles/fine lines
  - ☐ Forehead
  - ☐ Eyes
  - ☐ Nasolabial
  - ☐ Lips
  - ☐ Neck
- ☐ Facial scarring
- ☐ Dull/dry skin
- ☐ Excessive oil/shine
- ☐ Dark circles
- ☐ Bags/swelling under eyes
- ☐ Sun damage
- ☐ Rosacea
- ☐ Other: _____



Do you wear makeup daily? Yes / No

Do you wear sunscreen daily? Yes / No

What type of skin do you have?

☐ Normal ☐ Oily ☐ Dry ☐ Combination

COSMETIC HEALTH HISTORY

Have you had any of the following? (check all that apply):

- ☐ Been on Accutane
  - ☐ If so, when?
    _____
- ☐ Recent scarring
  - ☐ If so, where?
    _____
- ☐ Had Botox/facial/dermal fillers
  - ☐ If so, when & where?
    _____
- ☐ Had cosmetic surgery
  - ☐ If so, when & where?
    _____
- ☐ Recent Microdermabrasion/chemical peel
  - ☐ If so, when?
    _____
- ☐ Recent facial waxing/laser treatment
  - ☐ If so, when?
    _____

Do you currently have any (check all that apply):

- ☐ Active bacterial/fungal infections
- ☐ Allergic reaction
- ☐ Any skin diseases (poison ivy, eczema, hives)
- ☐ Dermatological diseases
- ☐ Collagen vascular disease
- ☐ Immune suppression
- ☐ Scleroderma
- ☐ Facial cancer (past / present)
- ☐ Bleeding disorder
- ☐ Pacemaker

GENERAL HEALTH HISTORY *(Check all that apply)*

HEAD:

- ☐ Concussion/Head trauma
- ☐ Headaches/Migraines
- ☐ Jaw pain/TMJ
- ☐ Dizziness/fainting
- ☐ None of the above

CARDIOVASCULAR:

- ☐ Palpitations
- ☐ Chest tightness/pain
- ☐ Bradycardia/tachycardia
- ☐ A-Fib
- ☐ Blood Clots
- ☐ Varicose Veins
- ☐ None of the Above

PSYCHO-EMOTIONAL:

- ☐ Anxiety
- ☐ Depression
- ☐ Mood Swings
- ☐ Irritability/anger
- ☐ Crying uncontrollably
- ☐ Fearful often
- ☐ PTSD
- ☐ None of the Above

Please check any CURRENT or PAST conditions you have experienced:

- ☐ Addiction/Alcoholism
- ☐ AIDS/HIV positive
- ☐ Arteriosclerosis
- ☐ Autoimmune disease
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ Hypertension
- ☐ Hypotension
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mono
- ☐ Neuralgia/Neuropathy
- ☐ Pacemaker
- ☐ Rheumatism/arthritis
- ☐ Shingles
- ☐ Stroke
- ☐ Syphilis
- ☐ Vein condition
- ☐ Venereal disease
- ☐ None of the Above

MEN'S HEALTH HISTORY

- ☐ Increase/decrease libido
- ☐ Groin/testicular pain
- ☐ Poor erectile function/impotence
- ☐ Premature/lack ejaculation
- ☐ Prostate problems
- ☐ Discharge from penis
- ☐ Other: _____
- ☐ Have you had a vasectomy? Y / N
- ☐ If so, when?_____

WOMEN'S HEALTH HISTORY

Please fill out to the best of your knowledge, even if you are no longer menstruating.

MENSTRUATION

Age when menses began: _____

Menstruation lasts _____days

I have a:

Regular cycle of _____days

Irregular cycle of _____to _____days

During your period, do you experience any:

- ☐ Dysmenorrhea (Cramps)
- ☐ Fatigue
- ☐ Breast tenderness
- ☐ Other: _____

During your period, the flow is:

Light/spotting on days _____

Medium on days _____

Heavy on days _____

What color is the blood?

Light Red on days _____

Bright Red on days _____

Dark Red on days _____

Brown on days _____

REPRODUCTIVE HISTORY

Are you currently using birth control? Y / N

Have you recently stopped or started birth control? Y / N

If so, when? _____

Are you trying to conceive? Y / N

Have you given birth in the last year? Y / N

Are you currently lactating? Y / N

Have you had any:

- ☐ High-risk pregnancies
- ☐ Difficult labor/deliveries
- ☐ Postpartum depression/concerns

MENOPAUSE

Are you perimenopausal? Y / N

Do you currently experience any:

- ☐ Night sweats/Cold flashes
- ☐ Hot flashes (daytime)
- ☐ Sleep Disturbance
- ☐ Spotting
- ☐ Other: _____

Are you postmenopausal? Y / N

When was your last period? _____

Have you had a hysterectomy? Y / N

If so, when? _____

Any pseudo period symptoms? Y/ N

FACIAL ACUPUNCTURE INFORMED CONSENT TO TREAT

Please read the below information carefully before signing the following consent.

Introductions - I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of facial/cosmetic acupuncture treatments and other procedures within the scope of practice on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below.

Benefits - Facial acupuncture can increase facial tone, decrease puffiness around the eyes, 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, other benefits may be seen as well.

Risks of Facial/Cosmetic Acupuncture - I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Although the majority of patients do not experience the following complications, you may experience bleeding, infection, damage to deeper structures, asymmetry, bruising and puffiness, nerve injury, needle shock, and allergic reactions.

Medical Changes - I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

Alternative Treatments - I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

Disclaimer - Informed-consent documents are used to communicate information about the proposed procedure along with disclosure of risks and alternative forms of treatment(s). Informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Subsequent alterations in facial appearance may occur as the result of the normal process of aging, weight loss/gain, sun exposure, or other circumstances not related to an acupuncture facial. An acupuncture facial 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 an acupuncture facial.

Consent For Facial Acupuncture Treatment

1. I hereby authorize _____SARAH JOHNSON_____ to perform acupuncture and additional accessory techniques on me. I have received the FACIAL ACUPUNCTURE INFORMED CONSENT TO TREAT and it has been explained to me in a way that I understand: the above treatment to be undertaken and the risks involved in the

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

2. I recognize that during the course of the acupuncture treatment, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above 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.

I Consent To The Treatment And The Above Listed Items (1-2). I Am Satisfied With The Explanation.

Patient Name *(Print)*

Patient Signature (*or Person Authorized to Sign for Patient***)**

Date

Notice of Privacy Practices (HIPAA) and Patients' Rights

_____ I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures of Sarah Johnson Acupuncture LLC before I sign this consent form regarding the use and disclosure of my Protected Health Information. I have the right to revoke this consent, in writing, at any time, exempting the acupuncturists and practice to the extent that they have already relied upon this consent.

Acknowledgement of Notice of Privacy Practices (HIPAA) and Patients' Rights

I acknowledge I have been given the opportunity to read a copy of the Notice of Privacy Practices (HIPAA) and Patients' Rights and fully understand both forms.

Patient Name *(Print)*

Patient Signature (*or Person Authorized to Sign for Patient***)**

Date