Acupuncture & Herb Center
Marlene Klein, LAc

Registration & Facial Questionnaire

Date: _____ Name: _____ Birthdate: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____ Preferred? _____

Email: _____ Occupation: _____

Emergency Contact & Phone: _____ Referred by: _____

Micro-current is a low level electric current very similar to our bodies' natural frequencies. While it is very safe, there are several contraindications we need to disclaim.

Please initial below acknowledging that you do <u>NOT</u> have any of the following conditions:

I am not pregnant _____ I do not have epilepsy _____ I do not have a pacemaker _____

I do not have active cancer (1 year or less) _____ I do not have a metal plate in face or head _____

What are your major facial concerns? _____

What are you hoping to accomplish with Facial Rejuvenation? _____

_____

Skin type: Normal _____ Dry _____ Combination _____ Oily _____ Sensitive _____

Skin conditions: Acne_____ Eczema _____ Itching_____ Skin Cancer_____
Skin Rashes _____ Rosacea _____ Skin Allergies _____ None_____

Medical:
Have you had a facelift? ____ When? _____ Have you had your eyes done? ____When? _____
Have you had a forehead lift? _____ When? _____ Cheek implants? ____ When? _____
Do you have Botox? _____ If yes, when was your last treatment? _____
Do you have fillers? _____ If yes, when, where and what? _____
Please list any medications you are taking and why below:

Please list any supplements/herbs you're taking and why below:

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What is your work environment like? _____
Are you on the computer a lot? _____Do you consider your work stressful? _____
Do you smoke? _____ How much do you smoke? _____ How long? _____
What is your leisure activity like? _____
Do you work out regularly? _____ How much sleep do you get on average? _____
Do you grind your teeth at night? _____ Do you wear a mouth guard? _____
Have you ever been told you have TMJ? _____ Are your temples tender? _____

What is your sun exposure history? _____ What is your tanning bed history? _____
Do you wear sunscreen? _____

How much water do you drink? _____How many glasses of alcohol do you have daily/weekly? _____
Do you crave sugar? _____ Salt? _____ Chocolate? _____
Do you eat late at night? _____

Do you bruise easily? _____ Do your feet, hands, ankles swell easily? _____
Do your eyes get swollen? _____ Do your hands or arms tingle while you're asleep? _____
Do you have neck and/or shoulder pain? _____ Do you have allergies? _____
Do you have a thyroid issue? _____ Are you sensitive to heat or cold? _____
Are your hands or feet cold often? _____

Hormonal (women only)
Have you been through menopause? _____ If yes, when? _____
Do you see someone for hormonal issues?_____ If yes, who and for what? _____
Do you have regular periods? _____ Are they painful? _____

Please sign and date:
_____ / _____

Practitioner's signature and date:
_____ /_____