Acton Wellness Center

Acupuncture | Chinese Herbal Medicine | NAET

Facial Rejuvenation Acupuncture Registration

PATIENT NAME: _____ **DATE:** _____

SKIN CARE HISTORY

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

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

2. What improvements would you like to see?

_____
_____
_____

3. Please describe any skin sensitivities or allergies:

_____
_____
_____

4. Do you wear makeup daily? Yes No Do you wear sunscreen daily? Yes No

5. Please describe your current skin care regimen and products that you use. (Toner, astringent, facial cleaner, moisturizer, exfoliator, masks, etc.):

_____
_____
_____

6. Do you go to tanning booths or sunbathe outdoors? Yes No Do you participate in vigorous aerobic activity or sport?

7. Do you get facial waxing/electrolysis or use depilatories? Yes, wait approximately 5 days between treatments No

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

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