ROCHESTER REGIONAL HEALTH
Clifton Springs Hospital & Clinic
The Springs Integrative Medicine Center and Spa

Constitutional Facial Acupuncture™ Intake Form

Name _____ Date of Birth _____ Today's Date _____

Have you received Botox injections in the last 6 months?	☐YES	☐NO
Have you had severe migraines in last 3 months?	☐YES	☐NO
Do you have any skin ulcerations or open wounds?	☐YES	☐NO
Have you had Laser skin resurfacing in last 3 weeks?	☐YES	☐NO
Have you had a Chemical peel in last 2 weeks?	☐YES	☐NO
Are you pregnant?	☐YES	☐NO

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS ABOVE, PLEASE CALL OUR OFFICE TO RESCHEDULE YOUR Constitutional Facial Acupuncture™ APPOINTMENT.

Have you ever had an acupuncture facial? ☐YES ☐NO
Do you bruise easily? ☐YES ☐NO
Do you take any medication that thins your blood? ☐YES ☐NO **If Yes, what medication?** _____
What is your blood type? _____ **Do you have a bleeding disorder?** _____

MEDICATIONS – Do you take/use any of the following medications?

Please list prescription & over the counter medications:	Please list Herbs, supplements, vitamins, etc:

ALLERGIES

Drugs/Medications	☐YES ☐NO	Specify:
Gluten	☐YES ☐NO	Specify:
Iodine/Seafood	☐YES ☐NO	Specify:
Other Foods	☐YES ☐NO	Specify:
Plants/Environmental	☐YES ☐NO	Specify:
Other	☐YES ☐NO	Specify:
Skin sensitivities/reactions to products/ingredients	☐YES ☐NO	Specify:

MAIN MEDICAL HISTORY (Please include dates):

Medical Diagnoses:
Surgeries:
Injuries:

What goals do you have for your Acupuncture Facial? _____

_____

ROCHESTER REGIONAL HEALTH
Clifton Springs Hospital & Clinic
The Springs Integrative Medicine Center and Spa

Constitutional Facial Acupuncture™ Intake Form

GENERAL (CHECK ALL THAT APPLY)

- □ AIDS/HIV
- □ Asthma
- □ Cancer
- □ Emphysema
- □ Lymph Nodes Removed
- □ Rheumatic Fever
- □ Alcoholism
- □ Hepatitis A/B/C
- □ Lyme Disease
- □ Multiple Sclerosis
- □ Polio
- □ Tuberculosis
- □ Birth Trauma
- □ Diabetes
- □ Heart Disease
- □ Herpes
- □ Mitral Valve
- □ Pacemaker
- □ Seizures
- □ Latex Allergy
- □ Varicose Veins
- □ Other _____

DIET

Food Cravings ? _____

Food Intolerances? _____

How many glasses/cups do you drink each day of the following:
Water _____ Soda _____ Coffee _____ Tea _____ Alcohol _____

How much of the following do you consume (# servings) per day/week:
Meat _____ Sugar/Sweets _____ Dairy/Milk/Cheese/Yogurt _____

Do you perspire during the day? ☐YES ☐NO
Do you perspire at night? ☐YES ☐NO
Are you always thirsty? ☐YES ☐NO
Do you prefer hot or cold drinks? ☐HOT ☐COLD

Taste Preferences – Rank the following according to your preference for each (Indicate 1-5 w/ 1=MOST LIKED -- 5= DISLIKED
Salty _____ Sour _____ Bitter _____ Sweet _____ Spicy _____

GASTROINTESTINAL (CHECK ALL THAT APPLY)

- □ Belching
- □ Nausea
- □ Vomiting
- □ Ulcers
- □ Bloating
- □ Indigestion
- □ Hernia
- □ Hemorrhoids
- □ Acid Reflux

Bowel Movements – how often? _____ day/week

- □ Irregular
- □ Constipation
- □ Diarrhea
- □ Gas
- □ Burning

EXERCISE & ENERGY (CHECK ALL THAT APPLY)

What kind of exercise do you engage in? _____ How often? _____

How is your energy level? _____

EMOTIONS & SLEEP (CHECK ALL THAT APPLY)

- □ Panic Attacks
- □ Depression
- □ Anxiety
- □ Nerves
- □ Fear
- □ Grief
- □ Poor Memory
- □ Difficulty Concentrating

Do you take antidepressants? ☐YES ☐NO If yes, what kind? _____
Do you take sleeping pills? ☐YES ☐NO If yes, what kind? _____

- □ Difficulty Falling Asleep
- □ Restless
- □ Disturbed Sleep
- □ Waking up @ _____am/pm

URINARY & GYN (CHECK ALL THAT APPLY)

How often do you urinate? _____ times per day. Color: _____

- □ Frequent urination
- □ Incontinence
- □ Burning
- □ Bladder Infections

Are you still menstruating? ☐YES ☐NO

- □ Irregular Menses
- □ Heavy Flow
- □ Light Flow
- □ No Flow
- □ Blood Clots
- □ PMS
- □ Painful Periods
- □ Uterine Fibroids
- □ Cystic Breasts

Are you peri-menopausal? ☐YES ☐NO
Symptoms: _____

Are you menopausal? ☐YES ☐NO
Symptoms: _____

ROCHESTER REGIONAL HEALTH
Clifton Springs Hospital & Clinic
The Springs Integrative Medicine Center and Spa

Constitutional Facial Acupuncture™ Intake Form

RESPIRATORY, ENT & HEAD (CHECK ALL THAT APPLY)

Do you smoke? ☐ YES ☐ NO If yes, _____ times/day for _____years

□ Frequent Colds	□ Dry Mouth	□ Migraine
□ Asthma	□ Ear Pain	□ Sinus Headache
□ Dizziness	□ Ringing in ears	□ Tension Headache
□ Cold Sores	□ Clogged/popping ears	
□ Bleeding Gums	□ Frequent Headache	

CARDIOVASCULAR (CHECK ALL THAT APPLY)

□ Palpitations	□ Spider Veins	□ Mitral Valve	□ Irregular Heartbeat
□ Varicose Veins	□ Cold Hands/Feet	□ Poor Circulation	

SKIN & HAIR (CHECK ALL THAT APPLY)

□ Dry Skin	□ Itching	□ Eczema	□ Hair Loss
□ Skin rashes	□ Acne	□ Hives	

Are there any additional health conditions/concerns I should be aware of? _____

_____

_____

The information I have provided is true and complete to the best of my knowledge. I agree to inform my practitioner of any changes in my health prior to treatment.

_____ _____

Patient Signature Date

FOR PRACTITIONER USE: