Matthew Richardson, R.Acu
420 Main St. E, Unit 102-103
Milton, ON L9T 1P9
905-878-8131

Facial Rejuvenation Acupuncture Intake Form

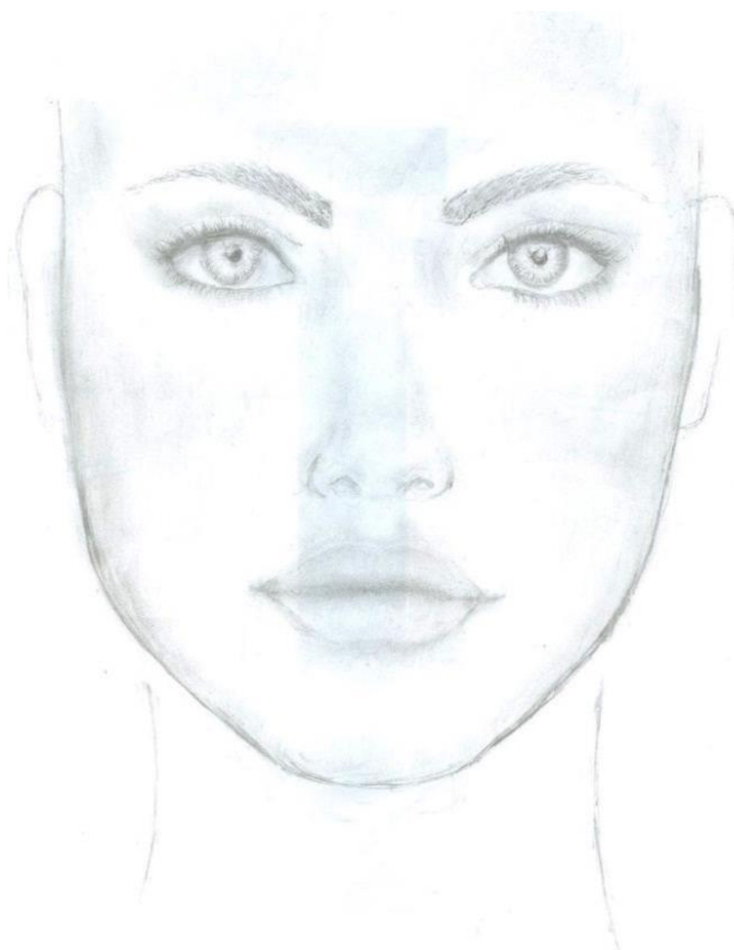
What are your goals/expectations for treatment**:** ____

____

____

Please describe, and indicate on the picture below, the concerns you have about your face and/or skin, in order of importance to you:

1. ____
2. ____
3. ____
4. ____
5. ____



General Medical and Cosmetic History:

The general state of your health is: Excellent ____ Good ____ Average ____ Fair ____ Poor ____

Are you on any prescribed/over-the-counter medications (including Advil, Tylenol, antacids):

Medication	Prescribed by: Self/MD/ND	Dose	Since when	Purpose

Previously diagnosed medical conditions, serious illness or hospitalizations with approximate dates:

____

____

____

Please indicate any cosmetic surgeries, or other cosmetic procedures that you have done in the past, with approximate dates. Also indicate any CURRENT procedures you are undergoing:

____

____

____

Please indicate any adverse reactions you may have had to any of the above-mentioned procedures:

____

____

____

Allergies: Medications | Environmental | Foods:

____

____

____

What is your current level of ENERGY from 1-10 (10 = best you have ever felt) _________

What is your current level of STRESS from 1-10 (10 = highest stress level felt) _________

What are your current sources of stress, and how do you cope?

____

____

____

Are you pregnant? ☐ Yes ☐ No

Do you have a bleeding/clotting disorder? ☐ Yes ☐ No
If yes, describe: ____

Do you bruise easily? ☐ Yes ☐ No
If yes, describe: ____

Have you recently, or are you currently taking any blood-thinning substances (pharmaceutical or natural) ☐ Yes ☐ No
If yes, describe (include brand, dose, frequency): ____
____
____

Describe your current skincare regime:

____
____
____

Please describe any other health issues or information, which may be helpful in our care for you:
____
____
____

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Diagnosis and Treatment Consent Form

I, the undersigned, do hereby give my voluntary consent for the administration of acupuncture, dry needling acupuncture techniques and other relevant Chinese medical therapies.

Acupuncture and the dry needling technique have been explained to me as a traditional Chinese medical treatment performed by the insertion of special sterilized fine needles with or without the application of electrical stimulation through the skin into the underlying tissues and muscles at specific points on the body for the purpose of alleviating pain and treating other clinical conditions.

Ancillary techniques of acupuncture may include one or more of the following:

- Moxibustion -whereby herbal heat is applied to specific acupuncture points
- Cupping- whereby suction cups are applied to specific points on the body or motion suction cups
- Auricular Acupuncture- whereby needles, press tacks, or ears seeds are inserted onto the surface of the ear in order to effect healing.

I have been made aware of the possibility of complications which may result from these procedures. These include infection (rare), bruising and bleeding into the tissues, pain and discomfort, weakness, tiredness, fainting, nausea, aggravation of existing symptoms for a short time, etc.

I state that I do not have the following conditions:

- Pregnancy
- Bleeding disorders
- Pacemaker
- Local infections
- Taking Anticoagulants (blood thinners)

If I have any of the above conditions, I have listed them here: ---

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I hereby certify that I have understood the above authorization and the risks involved. All relevant questions which I have asked have been answered.

Patient Name: (print) ---------------------------- Witness Name (print) -----------------------------

Patient Signature --------------------------------- Witness Signature ---------------------------------

Date ---