



COSMETIC ACUPUNCTURE HEALTH HISTORY (FACE & NECK)

Name _____ Age _____ Today's Date _____

Are you pregnant or planning on getting pregnant? Yes No

Have you had botox before? No / Yes (dates: _____)

Have you had other cosmetic procedures before? No / Yes (please list below)

How happy are you with your face and neck? Rate from 1-10 with 10 being the best: _____

What part of your face and neck do you LIKE the most?

What part of your face and neck do you DISLIKE the most?

What are your goals with cosmetic acupuncture?

What brand of skin care products do you use? _____

How happy are you with your skin care products? Love mine Might switch Want new ones

Which of the following products do you currently use?

<input type="checkbox"/> Cleanser:	_____	AM / PM / Weekly / Occasionally
<input type="checkbox"/> Toner:	_____	AM / PM / Weekly / Occasionally
<input type="checkbox"/> Serum:	_____	AM / PM / Weekly / Occasionally
<input type="checkbox"/> Cream:	_____	AM / PM / Weekly / Occasionally
<input type="checkbox"/> Eye Cream:	_____	AM / PM / Weekly / Occasionally
<input type="checkbox"/> Moisturizer:	_____	AM / PM / Weekly / Occasionally
<input type="checkbox"/> Sunscreen:	_____	AM / PM / Weekly / Occasionally
<input type="checkbox"/> Exfoliant / Scrub:	_____	AM / PM / Weekly / Occasionally
<input type="checkbox"/> Masque:	_____	AM / PM / Weekly / Occasionally
<input type="checkbox"/> Other:	_____	AM / PM / Weekly / Occasionally
<input type="checkbox"/> Other:	_____	AM / PM / Weekly / Occasionally