

# Client Initial Intake Form - Facial Rejuvenation

## Acupuncture, Massage & Wellness

Patients Name (Print) \_\_\_\_\_

Date of Birth \_\_\_\_\_

Age \_\_\_\_\_

 M F

Today's Date \_\_\_\_\_

Skin Type & Complexion: *Please check all that apply*

neutral

warm

cool

oily

dry

mixed

sensitive

dark

fair

yellow

red

### For Practitioner - Observation

Describe Eyes: \_\_\_\_\_

Skin/ Tone: \_\_\_\_\_

bright

dull

sagging

puffy

firm

smooth

patchy

thin

thick

Cheek Color: \_\_\_\_\_

Describe Hair: \_\_\_\_\_

Describe Lips: \_\_\_\_\_



What are your chief Concerns? \_\_\_\_\_

What are your Goals for this Treatment? What results do you expect to achieve? \_\_\_\_\_

Do you have any allergies? *Please list* \_\_\_\_\_

Are you allergic to Arnica?  Y  N  don't know

Are you taking Blood Thinning medication? Do you have a Bleeding or Clotting Problem?  Y  N

Are you Pregnant?  Y  N

Do you have frequent/ severe Migraines?  Y  N

Do you have severe or uncontrolled high blood pressure?  Y  N

Do have any of the following skin conditions? *Check all that apply*

Rosacea

Psoriasis

Other \_\_\_\_\_

Eczema

Acne

Notes: \_\_\_\_\_