

# Kimura Acupuncture

## Cosmetic Acupuncture Health Questionnaire

Aging is influenced by many factors. Your questionnaire provides valuable information which helps us understand the underlying causes of your health concerns. Please fill out the questions to the best of your ability and bring the form with you to your first visit to us.

### General Contact Information

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male / Female  
Address: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
(Preference: Home / Work / Cell )  
E-mail: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Emergency Contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Primary Physician: Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Facial Concerns

Please check  which of the following are of most concern to you:

- |   |   |
|---|---|
| <input type="checkbox"/> Bags / swelling under eyes | <input type="checkbox"/> Sagging face               |
| <input type="checkbox"/> Jowls                      |   |
| <input type="checkbox"/> Wrinkles                   | <input type="checkbox"/> Vertical creases / furrows |
| <input type="checkbox"/> Nasolabial (nose to mouth) | <input type="checkbox"/> Acne                       |
| <input type="checkbox"/> Eyes (crowsfeet)           | <input type="checkbox"/> Rosacea                    |
| <input type="checkbox"/> Lips                       | <input type="checkbox"/> Large pores                |
| <input type="checkbox"/> Other _____                | <input type="checkbox"/> Droopy eyelids             |
| <input type="checkbox"/> Premature graying of hair  | <input type="checkbox"/> Dry skin                   |
| <input type="checkbox"/> Lusterless skin            | <input type="checkbox"/> Age spots                  |
| <input type="checkbox"/> Sun damage                 | <input type="checkbox"/> Double chin                |
| <input type="checkbox"/> Broken capillaries         | <input type="checkbox"/> Acne scarring              |
| <input type="checkbox"/> Protruding temporal veins  |   |

Please describe your main skin complaint if it's not listed above.

What improvements would you like to see?

Please describe any skin sensitivities or allergies.

Please describe any other skin conditions/issues you have.

Please describe your current skin care regimen and products that you use. (Toner, astringent, exfoliation, masks, etc.)

Do you wear makeup daily? Yes / No Do you wear sunscreen daily? Yes / No

What procedures have you had or are currently undergoing?

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