



PATIENT INTAKE FORM - FACIAL REJUVENATION ACUPUNCTURE & MICRONEEDLING:

Client Name _____ Date _____
 Address: _____
 Phone HM: _____ Wk Phone: _____ Cell: _____
 Email: _____ (information kept private)
 Emergency Contact/Phone: _____ / _____
 Date of Birth ____ / ____ / ____ Age: _____ Gender: M / F
 Occupation: _____ Marital Status: _____ Number of Children _____
 How did you hear about us? _____

Because this is a holistic approach to healthcare, it is important for the practitioner to have a complete understanding of the patient; physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible, and print all information. If there is confusion on any area of the form, indicate with a question mark.

For best results a series of 10-15 treatments 2 times a week is recommended, followed by monthly and then seasonal maintenance treatments. Understand that results vary depending on health history, lifestyle, age and commitment to the frequency of treatments and lifestyle changes, including: diet, exercise, herbal and supplemental intake and home skin care regime.

COSMETIC FACIAL REJUVENATION ACUPUNCTURE:

What is your daily skin care routine?

What changes in your appearance and skin would you like to see happen?

When did your primary concern begin? _____

What about your skin and appearance is working for you?

Please check all that apply:

- Hyperpigmentation
- Wrinkles
- Crows Feet
- Nasal Labial Groove
- Double Chin
- Sagging/drooping, where: _____
- Acne/Breakouts
- Scarring
- Couperose/ Rosacea
- Uneven skin tone
- Enlarged Pores
- Dry Skin
- Oily Skin
- Other: _____

Previous Anti-aging treatments, Types/When: _____

Resurfacing treatments in last month? Type? _____

Botox treatments, When: _____

Plastic Surgery, What Kind/When: _____

Use of Retinol/Accutane/Glycolic in last Month

High blood pressure, Is it under control of MD? _____

Frequent Migraines, How often?, Last occurrence? _____

Additional Comments: _____



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MEDICAL HISTORY: (List any major past illnesses, injuries, surgeries with dates)

SIGNIFICANT FAMILY MEDICAL HISTORY: (List briefly and whom)

ALLERGIES OR SENSITIVITIES: (List foods, drugs, medications, metals or skin care products you are allergic or sensitive to (please include reaction):

LIFESTYLE:

Do you follow a regular exercise program? _____ If so, Please describe: _____

Relaxation Practice: _____

Sleep habits/hours of sleep per night: _____ do you feel rested? _____

Please describe your average daily diet:

Do you typically eat at least three meals per day? Y/ N If not, how many? _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

What particular diet or nutritional program do you generally follow? Example: (macrobiotic, vegetarian, meat & potatoes, low carb, etc.)

Please check any of the following habits that apply. Indicate how much and how often you consume them:

Cigarette smoking: _____ Coffee, tea, cola _____

Alcoholic beverages: _____ Recreational substances _____

MEDICATIONS/SUPPLEMENTS (prescribed and over-the-counter), herbs, vitamins and supplements you are currently taking or taken within last two months:



Please put a check next to conditions you have:

Immunity:

- Fatigue
- Chronic Fatigue
- Slow Healing
- Chronic Colds/Flu
- Chronic infections
- HIV/AIDS
- Other: _____

Head/Eyes/Ears/

Nose/Throat:

- Vision Problems
- Eye Pain/strain/redness/itching
- Floaters/see spots
- Blurry Vision
- Color Blindness
- Poor Vision
- Night Blindness
- Cataracts
- Glasses/Contacts
- Tearing/Dryness
- Dizziness
- Hearing Problems
- Ear Ringing
- Earaches
- Headaches
- Migraines
- Sinus Problems
- Nose Bleeds
- Facial Pain
- Frequent sore throats
- Teeth Grinding
- TMJ/Jaw Problems
- Seasonal Allergies
- Dental Problems
- Cold Sores

- Dry Mouth
- Bleeding Gums
- Convulsions
- Insomnia
- Other: _____

Respiratory:

- Cough
- Coughing up blood
- Asthma
- Bronchitis
- Pain with Inhalation
- Pneumonia
- Difficult Breathing
- Production of phlegm
- Frequent respiratory infections
- Other: _____

Cardiovascular:

- Hypertension/high blood pressure
- Hypotension/Low Blood pressure Heart
- Fainting
- Cold Hands/Feet
- Swelling of Hands/Feet
- Poor Circulation
- Chest Pain
- Blood Clots
- Palpitations
- Rapid heart beat
- Irregular heart beat
- Stroke
- Heart Murmurs
- Rheumatic Fever

- Varicose Veins
- Diabetes
- Hypoglycemia
- High Cholesterol
- Other: _____

GastroIntestinal:

- Nausea
- Vomiting
- Reduced Appetite
- Excess Appetite
- Change in Appetite
- Belching
- Acid Reflux
- Ulcers
- Epigastric Pain
- Excessive Gas
- Diarrhea
- Constipation
- Bloating
- Heartburn
- Abdominal Pain
- Weight Loss
- Weight Gain
- Food Cravings
- Excessive Thirst
- Gallbladder Problems
- Liver Disease
- Hepatitis A/B/C
- Hemorrhoids
- Other: _____

GenitoUrinary:

- Kidney Disease
- Painful Urination
- Frequent UTI
- Frequent Urination

- Venereal Disease
- Kidney Stones
- Urination Difficulty
- Blood In Urine
- Night Urination
- Other: _____

MusculoSkeletal:

- Muscle Spasms
- Aches/Pains
- Numbness/Tingling
- Edema
- Excess Sweating
- Cold Hands/Feet
- Cold Body Temp
- Hot Body Temp

Emotional:

- Mood Swings
- Irritability
- Nervousness/restless
- Stress
- Panic Attacks
- Fear
- Anxiety
- Sadness
- Difficult Concentration
- Forgetfulness
- Other: _____

Skin/Hair:

- Itching
- Hives
- Eczema
- Acne
- Skin Rashes



WOMEN'S HEALTH:

First day of last menses: _____ Age of first menses: _____
Typical duration of bleeding: _____ Length of menstrual cycle: _____ Is it regular?: _____ If not, explain: _____
Heavy bleeding or light flow? _____ Clotting? (size, quantity) _____
Color of blood (red, dark red, purple, brown, blackish): _____
Discomfort or pain during periods? _____ Stage of cycle? _____
breast tenderness during menses or ovulation? _____
Premenstrual symptoms? please specify: _____
Spotting between periods? _____
Have been diagnosed with: Fibroids? _____ Cysts? _____ Cervical dysplasia? _____
Pelvic inflammatory disease? _____ Unusual discharge? _____
Type of birth control? _____ How long? _____
Total # of Pregnancies: _____ Number of births: _____ Premature births: _____
Miscarriages: _____ Abortions: _____ Are you pregnant now? Yes / No / Maybe
Menopause?: _____ Age of Menopause: _____ Hot flashes? _____
Other Symptoms?: _____
Hormone replacement therapy? _____ Other treatments? _____

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Consent For Treatment - Facial Rejuvenation Acupuncture and Microneedling

I freely choose to undergo Facial Rejuvenation Acupuncture treatments and/or Microneedling with Amelia Vargas L.Ac., knowing that there are no guaranteed results, and I am free to stop treatment at any time. The goal of these treatments, is improvement - not perfection. I understand my results might not be perfect, and the number of treatments necessary may vary. There may be more treatments necessary than I anticipated. There is no guarantee that expected or anticipated results will be achieved. I understand that compliance with recommended Microneedling aftercare guidelines are crucial for healing and prevention of scarring or skin textural changes.

An acupuncture facial treatment involves the insertion of acupuncture needles into fine lines and wrinkles on the face and neck in order to reduce the visible signs of aging. In Oriental medicine, the meridians or pathways of Qi (energy) flow throughout the entire body from the soles of the feet up to the face and head; consequently, a facial acupuncture treatment addresses the entire body constitutionally, and is not merely “cosmetic.”

An acupuncture facial involves the patient in an organic, gradual process, that is customized for each individual. It is no way analogous to, or a substitute for, a surgical “face lift”. A treatment session may confine itself solely to facial acupuncture, or it may be used in conjunction with other procedures.

I understand that while acupuncture and microneedling are generally safe methods of treatment, certain adverse effects may result from treatment. These may be, but are not limited to local bruising (hematomas), puffiness, redness, bleeding, temporary pain or discomfort at the site of the needles during



or after the treatment, and in more rare circumstances there are the risks of fainting, infection, damage to blood vessels or nerves. In some circumstances, local allergies to topical preparations have been reported. Systemic reactions which are more serious may occur to herbs used during an acupuncture facial. Allergic reactions may require additional treatment.

With microneedling there may be redness, discomfort and/or swelling, or the sensation of having a sunburn at the area of treatment for 2-3 hours after treatment. Additionally redness may be present for 2-3 days after treatment. There may be an increase or decrease in pigmentation and can take 3-6 months or more to resolve. Loss of pigmented lesions such as freckles may give the appearance of loss of pigment. Small areas of scabbing may occur 2-3 days following the treatment. Infection is possible if proper aftercare guidelines are not followed.

I understand the methods of treatment in the scope of Chinese medicine may include but are not limited to acupuncture, microneedling, cupping, moxibustion (applying heat to acupuncture points of the body), electro-stimulation acupuncture, Tui-Na (Chinese massage), and herbal medicine.

Although noticeable results may be obtained with a single MicroNeedling or Facial Acupuncture treatment; the greatest improvement will be seen after a series of four to six consecutive monthly Microneedling procedures, ten to fifteen Facial Acupuncture sessions twice per week, or a combination of the two.

I understand the acupuncturist is not providing Western medical care, and I should look to my Western primary care physician (MD) for those services and routine checkups.

I understand I must inform my acupuncturist if I am **Pregnant**, have an **acute cold or flu**, an **acute herpes outbreak**, an **acute allergic reaction**, an **active inflammatory skin condition**, am **using accutane or any related acne medication**, **high blood pressure**, **diabetes**, **severe migraines**, am **HIV positive or have AIDS, cancer, or hepatitis**, as these may have additional risks or contraindications with facial acupuncture and microneedling.

I understand all fees for services are due at the time of service, and I will be charged the full fee for appointments that are cancelled with less than 24 hours notice.

I have read, or have had read to me, and completely understand the risks and benefits of acupuncture treatment, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present treatment and for any future condition(s) for which I seek treatment.

Printed Name: _____

Signature: _____

Date: _____



Colorado Mandatory Disclosure Form

Amelia Vargas earned her Master of Acupuncture and Oriental Medicine degree from South West Acupuncture College in Boulder Colorado. This four year program consisted of 3000 educational hours including 1095 hours of clinical practice. She is certified as a Diplomate in Acupuncture and Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). This includes certification in Clean Needle Technique and Chinese Herbology. Amelia's training also includes adjunctive therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy, facial renewal acupuncture, and dietary and lifestyle recommendations. She is a licensed Acupuncturist in the state of Colorado and is a member of the Acupuncture Association of Colorado. Additionally, Amelia is a Colorado licensed Esthetician and a practitioner of Acutonics and craniosacral therapy, and is certified in Facial Rejuvenation Acupuncture, Constitutional Facial Renewal Acupuncture, Facial Soundscapes Harmonic Renewal, and Oriental Medicine Pediatrics and Obstetrics. None of these licenses or certificates have ever been revoked or suspended.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Suggested Fee Schedule

Initial Consultation and Treatment 60-90 min - \$100
Follow-up Treatment 45-60 min - \$75
Pediatric Chinese Medicine 30 min - \$50
Cosmetic Facial Rejuvenation Acupuncture 60 min- \$125
Cosmetic Facial Acupuncture series of 10 - \$1,250
Cosmetic Facial Acupuncture Ultimate - \$195
Cosmetic Facial Acupuncture Ultimate Series - \$1,550
Microneedling Collagen Induction - \$300
Microneedling Series of 3 - \$810
Microneedling Series of 6 - \$1530

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.
- The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-2440.