BodyWise Acupuncture & Total Wellness

"Balance is the key"

****FACIAL REJUVENATION CLIENTS ONLY****

Name _____ Date _____

Please check if any of the following applies to you CURRENTLY:

☐ Migraines ☐ Seizure Disorders ☐ Hypertension ☐ Blood Thinning Drugs ☐ High Stress ☐ Pregnancy

What area of the face do you feel needs improvement? ☐ Forehead ☐ Eye Area ☐ Cheeks ☐ Neck ☐ Lips

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

☐ Bags/swelling under eyes
☐ Sagging face
☐ Wrinkles:
  ☐ Nasolabial (nose to mouth)
  ☐ Eyes (crow's-feet)
  ☐ Lips
  ☐ Forehead
  ☐ Other area: _____
☐ Vertical creases/ furrows
☐ Pre-mature graying of hair
☐ Droopy eyelids
☐ Double chin
☐ Oily skin
☐ Dry skin
☐ Lusterless skin
☐ Other issues: _____

What improvements would you like to see?

_____
_____
_____

Please describe any skin sensitivities or allergies:

_____
_____

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

Please describe your current skincare regimen and products that you use:

_____
_____
_____

Do you use tanning booths? ☐ Yes ☐ No Do you participate in vigorous exercise/sport? ☐ Yes ☐ No

THANK YOU!

FACIAL REJUVENATION ADDENDUM