|  |  |
| --- | --- |
| **Client** **Name:** | OSTeoMaureen Wellness Center Cosmetic Acupuncture |
| **Please** **take** **a** **few** **moments** **to** **fill** **out** **this** **questionnaire** **carefully.** **All** **answers** **will** **be** **held** **strictly** **confidential.** **If** **you** **have** **any** **questions,** **please** **feel** **free** **to** **ask.** | |

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code:\_\_\_\_\_\_\_\_ Home Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code:

How did you find us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal and Family Medical History:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Check those that apply: | **Yourself** | Mother | Father | Grandparents | Brother | Sister | Children |
| Allergies |  |  |  |  |  |  |  |
| Alzheimer’s |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |
| Bleeding Disorder |  |  |  |  |  |  |  |
| Cancer (note type) |  |  |  |  |  |  |  |
| COPD / Emphysema |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |
| Epilepsy |  |  |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |  |  |
| Heart Attack |  |  |  |  |  |  |  |
| Heart Trouble |  |  |  |  |  |  |  |
| Hepatitis |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |  |
| Liver Disease |  |  |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |  |  |
| Headaches |  |  |  |  |  |  |  |
| Pneumonia |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |
| Thyroid disorder |  |  |  |  |  |  |  |
| Tuberculosis |  |  |  |  |  |  |  |
| Ulcers |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

List any surgeries/injuries that you’ve had (include the year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Beauty Routine/History:

Cleanser \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Toner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Moisturizer \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mask\_\_\_\_\_\_\_\_\_\_\_\_

Do you use sunscreen? Yes No

Have you had facelift surgery? Yes No Full Partial

If so: When \_\_\_\_\_\_\_\_ Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Satisﬁed? Yes No Please Elaborate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facial Treatments: Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check what applies to you:

Skin

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Wrinkles |  | Oily |  | Sagging |  | Sallow (Yellow) Complexion |  |
| Blemishes |  | Eczema |  | Dullness |  | Rosacea (Redness) |  |
| Acne |  | Herpes |  | Psoriasis |  |  |  |
| Dryness |  | Rashes |  | Age spots |  |  |  |

Eyes

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Dark Eye Circles |  | Dry Skin around eyes |  | Puffy & Swollen |  | Eye Bags |  |
| Wrinkles |  | Styes |  | Puffy upper lids |  |  |  |

Neck

|  |  |  |  |
| --- | --- | --- | --- |
| Crepey Skin |  | Sagging Jowls |  |
| Wrinkles |  |  |  |

Lips

|  |  |  |  |
| --- | --- | --- | --- |
| Fine Lines |  | Cracking |  |
| Cold Sores |  | Herpes |  |

What Are Your Goals/Expectations For Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe below the concerns you have about your face and/or skin in order of importance to you:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed** **Consent** **for** **Cosmetic Acupuncture with Gentle Laser**

I hereby request and consent to the performance of **Cosmetic Acupuncture with Gentle Laser** by **Maureen Hannah Maher.**

I understand and am informed that there are some risks to treatment, including but not limited to bruising and local pain. **Also,** **I** **will** **notify** **the** **Acupuncturist** **who** **are** **caring** **for** **me** **if** **I** **am** **or** **become** **pregnant.**

I do not expect  **Maureen** to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on **Maureen** to exercise judgment during the course of treatment which **Maureen** thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

**By** **voluntarily** **signing** **below** **I** **show** **that** **I** **have** **read,** **or** **have** **had** **read** **to** **me,** **this** **consent** **to** **treatment,** **have** **been** **told** **about** **the** **risks** **and** **benefits** **of** **the** **Acupuncture** **and** **other** **procedures,** **and** **have** **had** **an** **opportunity** **to** **ask** **questions.** **I** **intend** **this** **consent** **form** **to** **cover** **the** **entire** **course** **of** **treatment** **for** **my** **present** **condition** **and** **for** **any** **future** **condition(s)** **for** **which** **I** **seek** **treatment** **from** **Maureen Hannah Maher.**

**Client’s** **Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** **Signed** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Facial** **Acupuncture** **Contraindications** Please inform if you:

-Are Pregnant or breastfeeding

-Have a bleeding/clotting disorder -Bruise easily

-Taking blood-thinning substances

-Had any invasive cosmetic treatments -Had botox or fillers

-Have uncontrolled blood pressure, have diabetes, or cancer -Have a pacemaker

**Cancellation** **Policy**

At our clinic, we all believe in respecting time. We will always do our best to prevent you from waiting before your appointments and/or having to change your appointments. We ask that, in return, you also respect our time. Please kindly give 24 hours notice if you need to change your appointment so another client can utilize that time slot. We reserve the right to charge full price for less then 24 hours cancellations and missed appointments (“no shows”.)

Please sign below indicating that you have read the policy and agree to its terms.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_