



The Foxwell centre
of holistic therapies

Facial Rejuvenation Acupuncture Questionnaire

| | |
|---|---------------------------|
| Full Name: | Date: |
| Address: | GP Name / Address: |
| D.O.B / Age: | Telephone Number: |
| Emergency Contact Details Name: Relationship: Telephone Number: | Occupation: |

Please state why you have chosen Facial Rejuvenation Acupuncture and what you would like to achieve with treatment:

1. Personal information

Please list any existing medical conditions, including chronic illnesses, pacemakers, major surgery etc:

Please list any prescribed medication:

Do you have any allergies?

Yes/No

Please list:

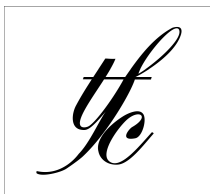
Any problems lying flat?

Yes/No

What time did you last eat/drink?

Eat:

Drink:



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2. Facial information

Complexion/Skin colour: Even/Red/Pale/Uneven/Rosacea/Patchy/Dark/Fair
Skin type: Oily/Normal/Dry/Flaky/Combination/Acne/Sensitive
Fine lines: Eyes/Mouth/Forehead/Chin
Deep lines: Eyes/Mouth/Forehead/Chin/Cheeks
Please list problem areas:

Describe your daily facial regime:

Do you wear makeup? Yes/No
If Yes, what and how often:

Do you remove makeup before you go to bed? Yes/No

3. General Information

Do you sleep well? Yes/No
Would you say you are stressed? Yes/No
If Yes, please list your stress levels: Low/Medium/High/Very High
Do you exercise regularly? Yes/No
Do you smoke? Yes/No
Do you take any recreational drugs? Yes/No
Daily water intake:
Daily caffeine intake:
Daily alcohol intake:



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Are you currently using any other products/alternative therapies/body work for your presenting condition? Yes/No

If Yes, please list:

Anything else you feel I should know about?