Facial Acupuncture
Initial Intake Form
Client Name:

Anna Totzke R.Ac
TouchStone Health
564-572 Weber Street North, Unit 3A
Waterloo, Ontario
N2L 5C6

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: _____ Sex: M / F 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):

_____
_____
_____
_____

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Medications

Medicine/Vitamins	Dosage	Reason

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	

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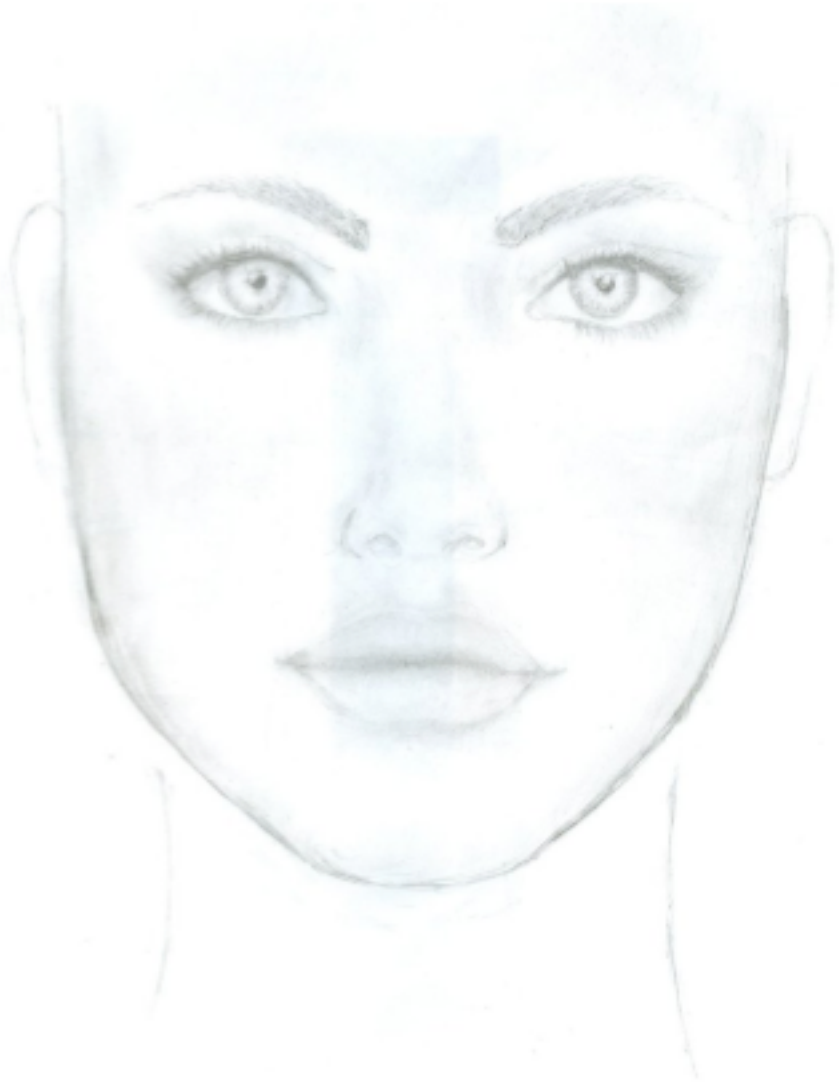
Facial Acupuncture Info:

What Are Your Goals/Expectations For Treatment:

_____
_____
_____

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

1. _____
2. _____
3. _____
4. _____
5. _____



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OTHER GENERAL HEALTH INFORMATION:

Pain:

1 2 3 4 5 6 7 8 9 10 (1 = Minimal pain, 10 = Extreme pain)

- ❑ Dull
- ❑ Lingering
- ❑ Sharp
- ❑ Burning
- ❑ Stabbing
- ❑ Distending
- ❑ Contracting
- ❑ Aggravated / Alleviated by:

Pressure Temp Climate

Head and Body:

- ❑ Headaches
- ❑ Migraines
- ❑ Body aches
- ❑ Joint pain
- ❑ Neck pain
- ❑ Back pain
- ❑ Low back pain
- ❑ Muscle pains
- ❑ Weak limbs
- ❑ Numbness
- ❑ Heaviness
- ❑ Stiffness

_____
_____
_____

Cold and Heat:

- ❑ Tidal Fever
- ❑ Cold
- ❑ Cold hands/feet
- ❑ Cold back
- ❑ Chills
- ❑ Heat
- ❑ Clammy hands/feet
- ❑ Fever

_____
_____

Sweating:

- ❑ Spontaneous
- ❑ With exertion
- ❑ No sweating
- ❑ Hot flashes
- ❑ Local sweats
- ❑ Night sweats

_____
_____

Energy: 1 2 3 4 5 6 7 8 9 10 (1 = Minimal energy, 10 = Maximal energy)

- ❑ Fatigue
- ❑ Fatigues easily
- ❑ Sudden energy drop
- ❑ Dizziness
- ❑ Excess
- ❑ Drowsy
- ❑ Dyspnea / SOB
- ❑ Fainting
- ❑ Heavy feeling

_____
_____

Sleep: _____ Hrs/night

- ❑ Sound, restful
- ❑ Insomnia
- ❑ Heavy sleep
- ❑ Dream disturbed
- ❑ Not restful
- ❑ Grinds teeth

_____
_____

Urine:

- ❑ Normal
- ❑ Polyuria
- ❑ Urgency
- ❑ Incontinence
- ❑ Nocturia
- ❑ Infrequent
- ❑ Dysuria
- ❑ Hematuria
- ❑ Clear
- ❑ Dark
- ❑ Excess
- ❑ Scanty

_____
_____
_____

Stool:

- ❑ Regular
- ❑ Diarrhea
- ❑ Constipation
- ❑ Loose/watery
- ❑ Foul smell
- ❑ Gas
- ❑ Dry, hard
- ❑ Burning
- ❑ Explosive

_____
_____

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Thirst:

❑ Thirsty w desire	❑ Likes cold drinks	❑ Dry mouth	_____
❑ Thirsty w no desire	❑ Likes hot drinks	❑ Bitter taste	

Appetite: 0 1 2 3 4 5 (0 = No appetite, 5 = Heavy)

❑ Cravings	❑ Vomiting	❑ Heartburn	_____
❑ Abdominal cramps	❑ Gas	❑ Bad Breath	
❑ Nausea	❑ Bloating	❑ Food Preferences	_____

Emotions:

❑ Calm/relaxed	❑ Angry	❑ Grief	_____
❑ Depressive	❑ Irritable	❑ Overthinking	
❑ Anxious	❑ Stressed	❑ Fearful	_____

Lifestyle and Body Type:

❑ Smoking	❑ Irregular hours	❑ Alcohol
❑ Weight gain / loss	❑ Shift work	❑ Caffeine
❑ Thin / Heavy	❑ Regular Exercise	❑ Occupational stress factors: _____

Eyes:

❑ Blurry vision	❑ Yellown	❑ Spots in front of	_____
❑ Poor vision	❑ Dry eyes	eyes	
❑ Eye pain	❑ Burning	❑ Red	_____

Ears:

❑ Poor Hearing	❑ Tinnitus	❑ Earaches	_____

Skin and Hair:

❑ Rashes	❑ Ulcerations	❑ Dandruff	_____
❑ Itching	❑ Eczema	❑ Hair loss	
❑ Dry skin	❑ Hives	❑ Changes in hair	_____

Gynecology:

❑ Regular	❑ Clots	❑ Discharge:	_____
❑ Irregular	❑ Heavy / Light flow	❑ PMS	
❑ Amenorrhea	❑ Pale / Dark colour	❑ Pain	_____

Age at first period: _____ Age at menopause: _____ Number of Pregnancies: _____

Time between cycles: _____ Duration of bleeding: _____ First day of last period: _____

Oral contraceptive use: _____ Type: _____ For how long: _____

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Informed Consent for Acupuncture Treatment

You are the most important person on your health care team. You are entitled to receive clear and understandable information about the options for and methods of therapy, techniques used, and duration of therapy. If you have questions about your treatment, please ask your attending traditional Chinese medicine practitioner to further explain it all pertinent information's in regards to your traditional Chinese medicine treatment. You may also seek a second opinion from another health care professional, or terminate therapy at any time.

I hereby request and consent to the performance of Acupuncture treatments and other procedures within the scope of the practice of Acupuncture on me by the Anna Totzke a Registered Acupuncturist.

I understand that methods of treatment may include, but are not limited to: acupuncture, cupping therapy, moxibustion, Chinese exercise therapy and Acupressure manual therapy.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is an also common side effect of cupping therapy. Anna Totzke R. Ac uses sterile disposable needles and maintains a clean and safe environment.

I understand and am informed that, as in the practice of acupuncture there are some risks to treatment, including but not limited to strains, 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 the Acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the Acupuncturist to exercise judgment during the course of treatment which the Acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. I understand the office medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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 A. Totzke.

Patient's Name _____

Patient's Signature_____ **Date Signed** _____

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Facial Acupuncture Contraindications

Please inform Anna Totzke, R.Ac 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

Fees, Insurance and Payment Agreement

The fees charged in our clinic are comparable to those charged by other specialists with similar qualifications in this geographic area.
The fees for the clinical services are payable at the time of the visit. For your convenience, we accept cash and personal checks.
If you carry extended health insurance covering for any service that we offer, we will provide you with the necessary invoices for you to receive reimbursement.

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: _____