Arizona Natural Medicine Physicians, P.L.L.C.

We Listen. We Care. We Change Lives. TM

Kiera Lane, N.M.D., L.Ac., Dipl. Ac., FABORM | Darin Zimmerman, L.Ac.

2480 W. Ray Road, Suite 1 • Chandler, AZ 85224 •P (480) 722-2811 •F (480) 722-2817

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Date _____

Facial Acupuncture Intake for Established Patients

Legal Name _____/_____/_____

Last Name **First Name** **middle initial**

Habits

Do you get regular exercise? ☐Yes ☐No What form/How often? _____

Do you drink alcohol? ☐Yes ☐No If yes, how much, how often, and what kind? _____

_____

Do you use other recreational drugs? ☐Yes ☐No If so, what kind and how often? _____

Do you use tobacco? If so, what kind, how much, and for how long have you used it? _____

Do you drink coffee? ☐Yes ☐No If yes, how much and how often? _____

Stress

Level of Stress? ☐ Low ☐ Moderate ☐ High Source of Stress? ☐ Work ☐ Financial ☐ Family/Relationship ☐ Other

Health Informati

Known Allergies: (to medications, foods, pollens, etc.)

_____

_____

Medications (include prescription and non-prescription items, dosage and frequency of use.)

_____

_____

_____

Supplements: (include vitamins, herbs, minerals, etc.)

_____

_____

_____

Review Of Systems/Chinese Medicine 10 Questions

HOT/COLD/BODY TEMP

Do you have the following? ☐ Chills ☐ Fever ☐ Chronic fever ☐ Alternating Chills with Fever ☐ Night Sweats

☐ Warm hands and feet ☐ Cold hands and feet ☐ Hot flashes in the afternoon or evening

Describe your body temperature normally? ☐ Chilly ☐ Warm ☐ Neutral

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HEENT

Which best describes your Headaches if applicable? ☐ Worse with fatigue ☐ One-Sided ☐ At Temples ☐ At Forehead ☐ At top of the head ☐ At back of head ☐ With Dizziness

Do you have the following? ☐ Dry eyes ☐ Watery eyes ☐ Blurred Vision ☐ Red Eyes ☐ Floaters ☐ Itchy Eyes ☐ High pitched ringing in the ears ☐ Low pitched ringing in the ears ☐ Difficulty Hearing ☐ Vertigo ☐ Dry Mouth ☐ Difficulty Swallowing ☐ Sensation of something stuck in throat ☐ Hoarseness

Which tastes if any do you have in your mouth? ☐ Bitter ☐ Sweet ☐ Sour ☐ Salty ☐ Pungent ☐ Metallic

Do you have? ☐ Stiff Neck ☐ Sore Throat ☐ Nose Bleeds ☐ Hearing Loss ☐ Dental Problems ☐ Sinus Drainage ☐ Sinus Pressure/Pain ☐ Runny Nose

CHEST (Respiratory/Cardiac)

Please check all, if any, that apply: ☐ Chest Pain ☐ Palpitations ☐ Heavy Sensation in Chest ☐ Shortness of Breath ☐ Irregular Heartbeat ☐ Exercise Intolerance ☐ Leg Swelling ☐ Asthma ☐ Wheezing ☐ Frequent Respiratory Infections ☐ Dry Cough ☐ Productive Cough

DIET

I would describe my diet as? (Check all that Apply)

☐ Standard American Diet ☐ Fast Food and Processed Foods ☐ Organic Whole Foods Diet ☐ Meat and Potatoes ☐ Vegetarian ☐ Gluten-Free ☐ Dairy-Free ☐ Balanced Whole Foods, Lean Proteins & Vegetables

How many meals do you generally eat per day? _____ How many snacks? _____

What kinds if any do you exclude from your diet? _____

THIRST/WATER INTAKE

Thirst? ☐ Low ☐ Moderate ☐ High I prefer: ☐ Cold drinks ☐ Warm drinks ☐ Room temperature

How many cups (12 oz.) of water do you drink per day? ☐ 1-4 ☐ 5-8 ☐ 8-10 ☐ More than 10

APPETITE/DIGESTION (Gastrointestinal)

Describe your appetite? ☐ Low ☐ High ☐ Normal

I crave the following foods? ☐ Sugary ☐ Salty ☐ Fatty ☐ Cold ☐ Hot ☐ Spicy ☐ Sour

I suffer from ☐ Gas ☐ Bloating ☐ Abdominal pain/discomfort ☐ Belching ☐ Acid Reflux ☐ Nausea ☐ Abdominal Pain ☐ Hemorrhoids ☐ Vomiting

STOOLS

Do you have? ☐ Constipation ☐ Loose Stools with undigested food ☐ Loose stools (before menses) ☐ Diarrhea ☐ Sticky stools ☐ Early morning diarrhea ☐ Alternating diarrhea and constipation ☐ Hard stools ☐ Bloody or Black Stools

URINATION

Do you suffer from ☐ Painful urination ☐ Incontinence ☐ Urinary frequency ☐ Frequent UTI ☐ Kidney stones

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☐ Diminished force of urinary stream ☐ Difficulty starting or stopping flow

Urine color is ☐ Dark ☐ Pale yellow ☐ Clear

SWEAT

I sweat/perspire? ☐ Seldom ☐ Moderately ☐ Often ☐ Excessively

I perspire in the area(s) of? ☐ Head ☐ Entire Body ☐ Under arms ☐ Other _____

MUSCULOSKELETAL/PAIN

Do you have any of the following? ☐ Joint Pain/Stiffness ☐ Joint Swelling ☐ Back Pain ☐ Muscle Weakness

☐ Muscle Spasm/Cramps

Do you have Pain? ☐ Yes ☐ No If yes, what is the location of pain? _____

Which describes your pain? ☐ Better with heat ☐ Better with pressure ☐ Worse with heat ☐ Worse with pressure

Seizurea

☐ Worse with damp weather ☐ Pain moves from place to place ☐ Pain worse with fatigue

☐ Pain associated with bloating or distention ☐ Sharp ☐ Stabbing ☐ Burning ☐ Dull ☐ Achy

Do you experience numbness or tingling in the hands or feet? ☐ No ☐ Yes If yes, explain_____

NEURO

Do you have the following symptoms? ☐ Seizures ☐ Fainting ☐ Dizziness ☐ Limb Weakness ☐ Balance Issues ☐

Tremors ☐ Rigidity ☐ Limb Numbness ☐ Swallowing Difficulty

SLEEP

Do you have the following? ☐ Difficulty falling asleep ☐ Waking at night due to heat ☐ Nightmares

☐ Waking or difficulty falling asleep because mind racing ☐ Insomnia of unknown reason ☐ Unrefreshing sleep

ENERGY

Typically my energy level is (0-10/10 ten is great energy, zero is no energy)_____

I am ☐ able to accomplish daily tasks ☐ struggle to accomplish daily tasks ☐ unable to accomplish daily tasks

EMOTIONS/MOOD

Do you have the following? ☐ Depression ☐ Anxiety ☐ Irritability ☐ Mania ☐ Anger/Agression ☐ Suicidal Thoughts

☐ Other_____

FEMALES

If Menstruating:

LMP _____Days between Cycles? _____How long do your periods Last? _____

Clots? ☐ No ☐ Yes If yes, size? ☐ Dime ☐ Nickel ☐ Quarter ☐ Half Dollar ☐ Larger than ½ Dollar

Cramps? ☐ Mild ☐ Moderate ☐ Severe Pain Quality? ☐ Stabbing ☐ Burning ☐ Achy ☐ Bear down Sensation

Do you have vaginal Discharge? ☐ No ☐ Yes

If **yes**, is it? ☐ Thin ☐ Thick ☐ Clear ☐ White ☐ Yellow ☐ Scanty ☐ Copious

Color of Menses? ☐ Dark Red ☐ Bright Red

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Do you have PMS symptoms? ☐ No ☐ Yes if yes, answer the questions below:

Premenstrual symptoms before your period (Mark below): (Grade intensity – 1=mild, 2=moderate, 3=severe)

___ Breast Tenderness ___ Bloating ___ Skin ___ Mood Changes _____
___ Headache ___ Cramping ___ Diarrhea ___ Appetite Changes _____
___ Low Back Pain ___ Constipation ___ Other

PMS symptoms occur? ☐ One week prior ☐ 2 weeks prior ☐ Few days prior ☐ Other _____

Do the above premenstrual symptoms get better with your period? ☐ No ☐ Yes

Are You Post-Menopausal? ☐ No ☐ Yes

Do you have the following symptoms now?

Hot flashes? ☐ No ☐ Yes Night Sweats? ☐ No ☐ Yes Insomnia? ☐ No ☐ Yes
Vaginal Dryness? ☐ No ☐ Yes Low Libido? ☐ No ☐ Yes

YOUR SKIN

YOUR SKIN TYPE/HISTORY

What is your skin type? ☐ Normal ☐ Oily ☐ Dry ☐ Sensitive ☐ Acne Prone ☐ Combination (oily in T=Zone)

Do you have any of the following conditions? ☐ Rashes/Hives ☐ Eczema ☐ Ulcers ☐ Psoriasis ☐ Lesions/Moles/Warts

What skin care products are you currently using? ☐ Soap ☐ Cleanser ☐ Toner/Astringent ☐ Moisturizer ☐ Masque ☐ Exfoliator ☐ Eye Care ☐ Sunscreen ☐ Other_____

What brand name of products for your skin do you currently use? _____

Have you ever experience ACNE breakouts? ☐ No ☐ Yes ☐ Occasionally

After 20 minutes in the sun do you? ☐ Always Burn ☐ Usually Burn ☐ Sometimes Burn ☐ Rarely Burn ☐ Never Burn

Have you had any of the following treatments? ☐ Microderm ☐ Chemical Peel ☐ Laser ☐ Resurfacing Treatment ☐ Peel ☐ Other_____

Do you have a tendency to scar? ☐ No ☐ Yes

Do you have any special areas of concern pertaining to your skin/face/neck? ☐ No ☐ Yes

If yes, please explain _____

Do you bruise easily? ☐ No ☐ Yes

Do you take any medications that thin your blood? ☐ No ☐ Yes Explain: _____

SKIN TREATMENT HISTORY

Have you ever received facials before? ☐ No ☐ Yes

Have you ever had acupuncture before? ☐ No ☐ Yes Have you ever had **facial acupuncture** before? ☐ No ☐ Yes

Have you been under a dermatologist or other physician's care over the past year for your skin? ☐ No ☐ Yes

If so, please explain for what and by whom you were treated? _____

Are you allergic to any known skin care ingredients? ☐ No ☐ Yes Explain _____

Have you received Botox? ☐ No ☐ Yes When was the last date of your treatment? _____

Are you currently using any of the following products? ☐ Glycolic Acid ☐ Salicylic Acid ☐ Exfoliating Scrubs ☐ Hydroxy Acid Products ☐ Cortisone ☐ Cleocin-T ☐ Sulphur ☐ Lactic Acid ☐ Vitamin A Derivatives (Example:Retinol)

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Have you bleached your skin? ☐ No ☐ Yes

If so what was the last product you used? _____

When was the last treatment? _____

Have you had any skin care treatment in the last 14 days? ☐ No ☐ Yes

If yes what type of treatment did you have? _____

YOUR SKIN CARE GOALS

What skin conditions do you want to improve?

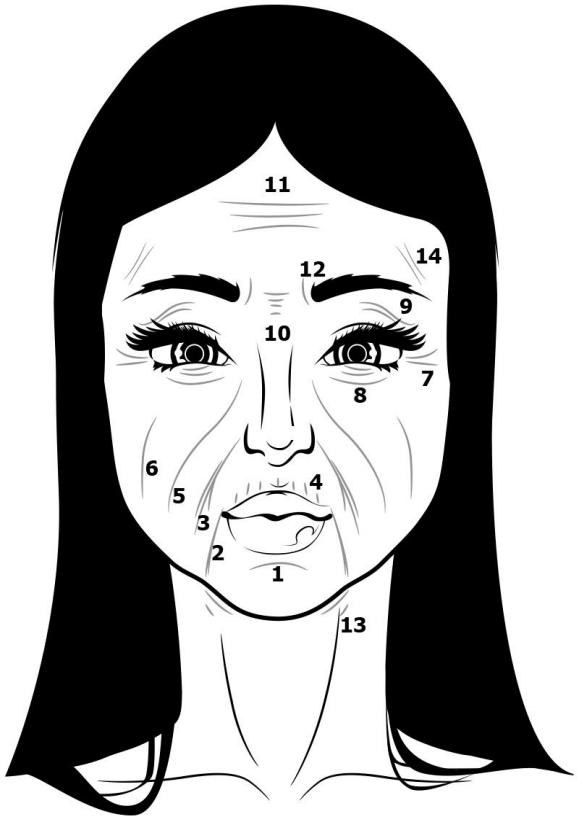
☐ Acne/breakouts ☐ Enlarged Pores ☐ Rosacea ☐ Dehydration ☐ Sun Damage ☐ Uneven Texture or Tone

☐ Hyper pigmentation (i.e. Age spots) ☐ Fine Line and Wrinkles Around Eyes ☐ Fine Line and Wrinkles Around Mouth

☐ Loose Skin of the Neck ☐ Fine Line and Wrinkles Around Eyes ☐ Other _____

FACE MAP

Indicate with the picture below the corresponding number for the top 3 areas you want to work on in order of priority (#1 = top priority). We will focus on the top two areas per each acupuncture 12 week series.



#1 Problem Area_____

#2 Problem Area_____

#3 Problem Area_____