Carie Bernard, L.Ac.

Acupuncture, Chinese Herbs and Facial Rejuvenation

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Name_____ **Date**_____

Street_____**City**_____**State/Zip**_____

Home Phone_____ **Work/Cell phone**_____

Email _____

Age_____ **Date of Birth**_____ **Male**_____ **Female**_____
Height_____**Weight**_____

Marital Status: Married/Partnered _____ Single _____ Widowed_____

Divorced or Separated_____

Education: Grammar School _____High School
_____College_____Masters_____Doctorate_____

Occupation:_____**Retired:**_____**Disabled:**_____**Unemployed:**_____

Family Dr. :_____**Referred by:**_____

Emergency Contact: _____**Relationship to you:**_____

Emergency Contact phone number/s:_____

Do you have any allergies?
_____

Are you currently using or have you ever used any form of Retin A or Renova? _____

Have you ever had a negative reaction to skin care products? If so, what: _____

Have you ever had any facial surgeries? If so, what: _____

Do you have any facial implants? _____

Have you ever had Botox, Juvederm or other facial injectables? If so, when: _____

Do you have any metal implants of any kind? If so, what type and where:

_____

Are you currently under the care of a doctor? Please explain:

_____

Please list all prescription medications or vitamin supplements you are currently taking:

_____

_____

Do you have migraines that are triggered by flashing lights? _____

For women: Are you currently pregnant or trying to become pregnant? _____

Do you have or have you ever had high blood pressure or any cardiac issue? _____

Do you have a cardiac pacemaker? _____

Do you or have you ever had lesions, growths or cancer of the brain, head or face? _____

Have you ever had a seizure? _____

Have you ever been diagnosed with epilepsy or a seizure disorder? _____

Have you ever had a trauma to the head? (Concussion, fracture, stitches, loss of consciousness after hitting your head, whiplash or other) _____

Please list all hospitalizations, accidents or major illnesses going back to childhood:

_____

_____

_____

_____

Please describe your typical daily diet:

_____

_____

How much water do you drink per day? _____

How many alcoholic beverages do you drink per week?_____

Do you now or have you ever used recreational drugs? _____

Do you now or have you ever smoked cigarettes? If so how many per day for how long?

_____

What is your history of sun exposure?_____

Do you wear sunblock?_____

Do you have any other concerns that you would like to discuss? _____