



**APPLICATION FOR COSMETIC ACUPUNCTURE PROGRAM**

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

**What are your expectations?**

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**How many ounces do you drink per day of:** Water \_\_\_ Coffee \_\_\_ Green Tea \_\_\_ Black Tea \_\_\_ Soda \_\_\_ Energy Drink \_\_\_?

**Do you drink alcoholic beverages? \_\_\_\_\_ How many per day/week/month? \_\_\_\_\_**

**Are you currently a smoker? \_\_\_\_\_ If so, how many cigarettes per day \_\_\_ or week \_\_\_? Number of years: \_\_\_\_\_**

**Have you been a smoker in the past? \_\_\_\_\_ Number of years? \_\_\_\_\_ Year quit? \_\_\_\_\_**

**Are you currently pregnant? \_\_\_\_\_ Is there a possibility you may be? \_\_\_\_\_ Are you trying to become pregnant? \_\_\_\_\_**

**Describe the type and amount of exercise in your life:**

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How would you describe your stress level? \_\_\_\_\_ Hours of sleep per night? \_\_\_\_\_ Quality? \_\_\_\_\_

Describe your skin care regimen: \_\_\_\_\_

Product and brands used: \_\_\_\_\_

Do you use a moisturizer daily? \_\_\_\_\_ Do you use sunscreen daily? \_\_\_\_\_ Do you wear makeup daily? \_\_\_\_\_

Are you currently under care of a dermatologist? \_\_\_\_\_ For what condition? \_\_\_\_\_

Do you currently receive care from an esthetician (peels, facials, etc.)? \_\_\_\_\_

When outdoors, do you use sunscreen? \_\_\_\_\_ How many times have you had sunburn in your life? \_\_\_\_\_

Do you currently use a tanning booth? \_\_\_\_\_ How often? \_\_\_\_\_ Have you in the past? \_\_\_\_\_ How often? \_\_\_\_\_

Are you taking any *vitamins* or *supplements*? If so, please list brand, type, and amount:

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Are you currently taking any *prescription* or *over-the-counter* medication? If so, please list type, dosage, condition:

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Have you ever suffered a stroke? \_\_\_\_\_ Migraines? \_\_\_\_\_

Describe any significant diseases, conditions or past surgeries (including date):

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**What procedures have you had or are currently undergoing? (Botox, collagen, laser, microdermabrasion, surgery, etc.):**

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