



*Cosmetic Acupuncture Medical History Form*

Name: \_\_\_\_\_  
(Last) (First)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Please list your main areas of concern that you wish to improve with cosmetic acupuncture:**

**Please list all medications (prescription, over-the-counter) and natural products (vitamins, herbs, oils) you are currently taking, including the dose and reason.**

**Please list any allergies or sensitivities (food/environmental, medications) you currently have or have had previously.**

**Please list all hospitalizations, surgeries, major injuries AND cosmetic procedures you have experienced or had (including the year, outcome, and any complications).**

**Please check off any of the following conditions that apply to you.**

- Under 18 years of age
- Pregnant or nursing
- Current or history of cancer
- Current or history of pre-malignant moles or skin cancer
- Any active condition in the treatment area such as sores, active pustular acne, rosacea, keloid or raised scars, septic conditions, psoriasis, eczema, rash
- Consistent tanning either outside or in tanning bed
- Damaged skin due to excessive fresh tanning

**Lifestyle**

Are you currently or have you ever been a smoker?

Past  Never  Currently

*If so, how many packs a day?*

\_\_\_\_\_

*How long have you smoked or when did you quit?*

\_\_\_\_\_

How much time do you spend outdoors per week?

\_\_\_\_\_

How often do you exercise?

\_\_\_\_\_

What kind of exercise do you do?

\_\_\_\_\_

**Diet**

How much water do you drink per day?

\_\_\_\_\_

How many times per week do you eat red meat or deli meat?

\_\_\_\_\_

How many caffeinated beverages do you drink a week?

\_\_\_\_\_

How much refined sugar do you eat/drink a week?

\_\_\_\_\_

Do you have any dietary restrictions?

Yes  No

*If so, please specify (e.g. vegan, religious, allergies)*

\_\_\_\_\_

Is there anything you feel is important to note that has not been covered in this questionnaire?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I, the undersigned pledge to inform of all changes in my physical condition.**

**I confirm that I do not suffer from any of the above described conditions.**

**I declare that the above information is true and correct.**

Patient Name:

\_\_\_\_\_

Patient Signature:

\_\_\_\_\_

Date:

\_\_\_\_\_

Practitioner Name:

\_\_\_\_\_

Practitioner Signature:

\_\_\_\_\_

*Thank you for completing this form.*

*This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us.*



*Contact Information & Consent*

Name: \_\_\_\_\_  
(Last) (First) (Preferred name)

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (mm/dd/yyyy)

Occupation \_\_\_\_\_

Full Address: \_\_\_\_\_  
\_\_\_\_\_

Postal Code: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work/Mobile: \_\_\_\_\_

Email (for appointment reminders and follow-up): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Telephone: \_\_\_\_\_

**How did you hear about Zawada Health?**

- Search Engine
- Zawada Health Website
- Yellow Pages
- Health Fair
- Relative or Friend
- Coworker
- Medical Doctor
- Chiropractor
- Health Food Store
- Registered Massage Therapist
- Other Healthcare Practitioner: \_\_\_\_\_
- Other (please specify): \_\_\_\_\_

\*\*With the **new email legislation**, we require your approval to send you our monthly newsletter, which includes exciting information, delicious recipes, and more (*only one email per month*).

Signature: \_\_\_\_\_ Email: \_\_\_\_\_



Acknowledgement and Informed Consent

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration the physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include dietary modification and nutritional supplementation, lifestyle counseling, botanical medicine, homeopathy, traditional Chinese medicine & acupuncture, hydrotherapy, and physical medicine.

During your initial visits your Naturopathic Doctor will take a thorough case history, perform a basic/complaint-oriented physical examination, and when indicated take urine samples or perform other laboratory testing. Even the gentlest therapies may cause complications in certain physiological conditions. This depends dramatically on the individual and the extent of the illness.

Some therapies must be used with caution in certain conditions or diseases such as diabetes, heart/liver/kidney disease, or in young children, those taking multiple medication or pregnancy/lactation. Therefore, it is very important that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, please advise your Naturopathic doctor immediately.

Health risks associated with Naturopathic Medicine include, but are not limited to:

- Aggravation of pre-existing symptoms during the healing process
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture
- Fainting or puncturing of an organ with acupuncture needles
- Inconvenience of lifestyle changes

The Naturopathic Doctor may prescribe supplements that can be purchased at the clinic or other local options (i.e. health food stores). Most insurance companies do not cover the supplements that we prescribe and dispense.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

Print Parent/Guardian's Name: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_