Facial Rejuvenation Patient Form

Date: _____

Your patient form provides valuable information which helps me understand the underlying causes of your health concerns. Please complete the questions to the best of your ability and bring the form with you to your first visit. All information is kept confidential.

General Information

Name: _____ Age: _____ Birth date: _____

Address:_____ State: _____ Zip code: _____

Phone (cell): _____ (home): _____

Email address (print clearly): _____ Occupation: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Primary Physician: _____ Phone: _____

How were you referred to Bodyscapes?

□ Referral □ Internet □ Mailing □ Event □ Flyer □ Other: _____

Facial Concerns Please check all that are of most concern to you

□ Bags/swelling under eyes
□ Jowls
□ Wrinkles
  □ Nasolabial (nose to mouth)
  □ Eyes (crows feet)
  □ Lips
  □ Other _____
□ Premature graying of hair
□ Hair loss
□ Lusterless skin
□ Sun damage
□ Broken capillaries
□ Protruding temporal veins
□ Sagging face
□ Vertical creases/furrows
□ Acne
□ Rosacea
□ Large pores
□ Droopy eyelids
□ Dry skin
□ Age spots
□ Double chin
□ Acne scarring
□ Eczema
□ Psoriasis
□ Rash
□ Fungal infection

What improvements would you like to see?

Please describe any skin sensitivities or allergies.

Please describe any other skin conditions/issues you have.

Please describe your current skin care regimen and products that you use (toner, astringent, exfoliation, masks, etc.).

Do you wear makeup daily? □ Yes □ No Do you wear sunscreen daily? □ Yes □ No

What procedures have you had or are currently undergoing?

	Dates		Dates
□ Botox injections	_____	□ Laser procedures	_____
□ Collagen injections	_____	□ Threading (lift)	_____
□ Restalyne	_____	□ Rhytidectomy	_____
□ Silicon injections	_____	□ Blepharoplasty	_____
□ Mesotherapy	_____	□ Brow or coronal lift	_____
□ Microdermabrasion	_____	□ Other:	_____
□ Chemical peels	_____		_____

General Health

Do you take any medications (include over-the-counter)?

Name of medication	Reason for taking it
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Please list any supplements you are taking: _____

Have you had any long-term or frequent use of antibiotics? Yes No Describe: _____

Please indicate if you have or have had any of the following conditions:

□ Pneumonia	□ Hepatitis	□ Epilepsy
□ Tuberculosis	□ Diabetes	□ Kidney stones
□ Drug reaction	□ Blood transfusion	□ Arthritis
□ Heart attack	□ Anemia	□ STD
□ Mental breakdown	□ Jaundice	□ Measles
□ Obesity	□ Parasites	□ Mumps
□ HIV/Aids	□ Low blood pressure	□ Gout
□ High blood pressure	□ Heart disease	□ Cancer
□ Mental illness	□ Seizures	□ Crohn's
□ Hyperthyroid	□ Multiple sclerosis	□ IBS
□ Hypothyroid	□ Autoimmune	□ Colitis
□ Premature graying	□ Osteoporosis	□ Dementia

Sleep

Do you sleep well? □ All the time □ Most of the time □ Some of the time □ Hardly ever

Do you fall asleep easily? Yes No	Do you have lots of dreams? Yes No
Do you feel rested when you wake? Yes No	Do you have sleep apnea? Yes No
Do you wake during the night? Yes No	Do you get night sweats? Yes No
Do you fall back to sleep easily? Yes No	Do you nap during the day? Yes No

Average hours of sleep per night: _____ Energy level (10 being best)? 1 2 3 4 5 6 7 8 9 10

Physical Activity

Do you exercise? Yes No How often? _____ How long? _____
What types of exercise do you do? _____ Do you like to exercise? Yes No
Check physical activities you enjoy:

□ Walking □ Camping □ Weight training □ Zumba
□ Running □ Boating □ Stretching □ Yoga
□ Swimming □ Outdoor sports □ Personal training □ Tai chi
□ Cycling □ Hiking □ Pilates □ Qi gong
□ Spinning □ Team sports □ Dance □ Martial arts

Mental/Emotional State Check all that apply to you

□ Happy □ Worry □ Irritable
□ Anger □ Grief □ Frustrated
□ Depression □ Sadness □ Memory loss
□ Sluggish thinking □ Fearful □ Other _____
□ Foggy thinking □ Panic attacks
□ Anxiety □ Poor concentration

Are you currently under any unusually high stress? _____ Explain: _____

Respiratory System Check all that apply to you

□ Allergies □ Sinus headache □ Dry mouth/throat □ Asthma
□ Ear ache □ Frequent colds □ Tongue sores □ Bronchitis
□ Tinnitus □ Cough/wheezing □ Canker sores □ Lung congestion
□ Sinus congestion □ Excessive phlegm □ Bad breath □ Enlarged glands
□ Sinus infection □ Sore throat □ Shortness of breath □ Chills/Fever

Cardiovascular System Check all that apply to you

□ Chest pain
□ High blood pressure □ Shortness of breath □ Cold hands/feet
□ Low blood pressure □ Dizziness □ Poor circulation
□ Palpitations □ Fatigue

Urinary System Check all that apply to you

□ Scanty urination □ Bladder infections □ Swollen hands or feet
□ Profuse urination □ Frequent PM urination □ Discharge
□ Low back pain □ Lack of bladder control □ Burning
□ Kidney stones □ Difficult urination □ Urgency

What color is your urine? □ Clear □ Yellow □ Dark yellow □ Reddish

Skeletal System Check all that apply to you

□ Broken bones □ Scoliosis □ Bulging disc □ Lots of cavities
□ Fractures □ Spinal stenosis □ Osteoarthritis □ TMJ dysfunction
□ Dislocations □ Spondylolisthesis □ Rheumatoid arthritis □ Teeth grinding
□ Osteoporosis □ Bone spurs □ Bursitis
□ Osteopenia □ Degenerating disc □ Joint swelling

Neuromuscular Check all that apply to you

□ Muscular pain □ Migraine □ Tingling □ Shin splints
□ Low back pain □ Tension headache □ Neuropathy □ Plantar fasciitis
□ Sciatica □ Muscle cramps □ Fibromyalgia □ Other _____
□ Neck pain □ Muscle twitching □ Tendonitis
□ Shoulder pain □ Numbness □ Carpal tunnel

Eyes/Ears Check all that apply to you

□ Red eyes
□ Itchy eyes
□ Dry eyes
□ Eye pain/strain
□ Spots in eyes
□ Floaters
□ Blurry vision
□ Ear infection
□ Vertigo
□ Meniere's disease
□ Tinnitus
□ Hearing loss

Gastrointestinal System Check all that apply to you

□ IBS
□ Constipation
□ Diarrhea
□ Loose stools
□ Fluctuating stools
□ Blood in stools
□ Colitis
□ Ulcers
□ Mucus in stools
□ Putrid/smelly
□ Hemorrhoids
□ Bloating
□ Gas
□ Acid reflux
□ Crohn's disease
□ Nausea
□ Abdominal pain
□ Tongue sores
□ Bad breath
□ Bruise easily

Diet

How is your appetite? _____How many meals per day do you eat? _____ Bowel movements per day? _____
Are you thirsty? _____ How much water do you drink per day? _____ Prefer cold or hot beverages? _____
Do you drink caffeine? _____ How many cups per day? _____ List other beverages you drink including juice, rice milk, almond milk, soy milk, tea, etc. _____
What dairy products do you eat? _____ Are you lactose intolerant? _____
Are you a vegetarian or vegan? _____ List sources of meat/protein: _____
What % of your diet is organic? _____ Do you have any particular cravings? _____
List any food allergies or sensitivities: _____
Fast food per week? _____ Times per week you eat out? _____ Do you eat a lot of processed food? _____
Eat late at night? _____ Chew your food well? _____ Get enough fresh fruits, vegetables, and whole grains daily? _____
Drink alcohol? _____ How much? _____ Do you smoke cigarettes? _____ How much? _____
How would you describe your diet? □ Unhealthy □ Fair □ Good □ Fantastic
How would you rate your cooking skills on a scale of 1-10 (10 being best)? 1 2 3 4 5 6 7 8 9 10
Are you ready and willing to make changes in your diet if need be? _____

Body Temperature Check all that apply to you

□ Feel cold often
□ Dislike the cold
□ Cold hands
□ Cold Feet
□ Feel hot often
□ Dislike the heat
□ Afternoon flushes
□ Night sweats
□ Perspire easily
□ Lack of perspiration
□ Heat in soles, hands, and chest

Women's Health

Are you currently pregnant or trying to get pregnant? _____If pregnant, how many weeks? _____ Due date? _____
Are your periods regular (26-32 days)? _____ If not, describe: _____
How many days does your period last? _____ Are you currently going through fertility treatment? _____

Please check any of the following that apply to you:

□ Birth control pills
□ Painful periods
□ Heavy flow
□ Scanty flow
□ Clots
□ Anemia
□ Bruise easily
□ PMS
□ Spotting before period
□ Mid-cycle spotting
□ Hormonal imbalance
□ Irritability
□ Insomnia
□ Breast tenderness
□ Breast cancer
□ Breast lumps
□ Fibroids
□ Migraine
□ Infertility
□ Endometriosis
□ PCOS
□ Vaginal discharge
□ Yeast infections
□ Menopause
□ Hot flashes
□ Night sweats
□ STD
□ HRT

Thank you for completing this form. All information is kept confidential.