RED PHOENIX ACUPUNCTURE

Dr. Amy Bonnett, DOM

4041 Barbara Loop, Suite A
(505) 896-6965

Cosmetic Patient Information Sheet

Patient Information

Name ______________________ Date ____________

Address ______________________ City ____________ State _______

Zip __________ Home phone ____________ Work phone ____________ Cell ____________

Email ______________________ Have you had acupuncture before? ☐ Yes ☐ No

Height ________ Weight ________ Age ______ Sex: ☐ Male ☐ Female Date of birth ____________

Occupation ______________________ Employer ______________________

In emergency notify (name): ______________________ Emergency phone number: ____________

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed ☐ Separated

Number of children: __________ Ages of children: ____________ Number who live with you: ________

Others living with you: ______________________

Primary Care Doctor ______________________ Last seen: ____________

How did you hear about Red Phoenix Acupuncture: ☐ Yellow Pages ☐ Article ☐ A Talk

☐ Brochure ☐ Business Card ☐ Web site ☐ Referred by: ______________________

Cosmetic Information

What is the skin condition you would like treated today? ______________________

Please prioritize the cosmetic improvements you would like to see in your skin:

1.____________ 2.____________ 3.____________

Are there any particular areas of concern for you? ______________________

Do you feel like your skin is: OILY DRY NORMAL COMBINATION

Please CIRCLE any skin conditions you currently have or have had in the past:

Skin cancer Shingles Herpes Cold Sores Acne Rosacea Eczema Psoriasis

Any other skin conditions?: ______________________

Do you have any allergies or skin sensitivities? Please list ______________________

What brand of skin care products do you use? ______________________

Please CIRCLE the types of skin care products you use on your face:

Cleanser Soap Scrub Mask Toner Astringent Nose Strips

Moisturizer Dermabrasion Eye Cream Acne Medication Other: ____________

Do any of the products contain?: Alpha Hydroxy Vitamin C Vitamin A

What temperature water do you use to clean your face? Hot Warm Lukewarm Cool Cold

Do wear makeup daily? __________ What brand(s)? ______________________

Do you wear sunscreen daily? __________ SPF? __________ Do you tan? ____________

Have you ever had cosmetic surgery or procedures? Please list: ______________________

____

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Health Inventory

Cardiovascular Conditions:
- [ ] Heart Disease
- [ ] A Pacemaker
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Chest Pain
- [ ] Palpitations
- [ ] Stroke
- [ ] Varicose Veins
- [ ] Edema

Emotional / Mental:
- [ ] Clinical Depression
- [ ] Mild Depression
- [ ] ADD or ADHD
- [ ] Schizophrenia
- [ ] Mood Swings
- [ ] Panic Attacks
- [ ] Nervousness
- [ ] Anxiety
- [ ] Alzheimer's
- [ ] Dementia

Energy & Immunity:
- [ ] Chronic Fatigue Syndrome
- [ ] General Fatigue
- [ ] Slow Wound Healing
- [ ] Easy Bruising
- [ ] Chronic Infections
- [ ] Frequent Allergies

Respiratory:
- [ ] Pneumonia
- [ ] Asthma
- [ ] Frequent Common Colds
- [ ] Difficulty Breathing
- [ ] Emphysema
- [ ] Persistent Cough
- [ ] Pleurisy
- [ ] Tuberculosis
- [ ] Shortness of Breath

Musculo-Skeletal:
- [ ] Neck / Shoulder Pain
- [ ] Muscle Spasms / Cramps
- [ ] Arm Pain
- [ ] Upper Back Pain
- [ ] Mid Back Pain
- [ ] Low Back Pain
- [ ] Leg Pain
- [ ] Osteoporosis
- [ ] Arthritis
- [ ] Joint Pain

Head, Eye, Ear, Nose & Throat:
- [ ] Impaired Vision
- [ ] Eye Pain/Strain
- [ ] Glaucoma
- [ ] Glasses / Contacts
- [ ] Tearing / Dryness
- [ ] Impaired Hearing
- [ ] Ear Ringing
- [ ] Earaches
- [ ] Ear Infections
- [ ] Headaches
- [ ] Sinus Problems
- [ ] Nose Bleeds
- [ ] Teeth Grinding
- [ ] Frequent Sore Throats
- [ ] TMJ / Jaw Problems
- [ ] Hay Fever

Genito-Urinary Tract:
- [ ] Kidney Disease
- [ ] Kidney Stones
- [ ] Painful Urination
- [ ] Dribbling Urination
- [ ] Frequent UTI
- [ ] Frequent Urination
- [ ] Blood in Urine
- [ ] Discharge
- [ ] Incontinence

Neurological:
- [ ] Vertigo / Dizziness
- [ ] Paralysis
- [ ] Numbness / Tingling
- [ ] Loss of Balance
- [ ] Seizures / Epilepsy
- [ ] Dyslexia

Gastrointestinal:
- [ ] Stomach Ulcers
- [ ] Changes in Appetite
- [ ] Nausea / Vomiting
- [ ] Epigastric / Abdominal Pain
- [ ] Passing Gas
- [ ] Heart Burn
- [ ] Belching
- [ ] Gall Bladder Disease
- [ ] Gall Bladder Stones
- [ ] Hemorrhoids
- [ ] Constipation
- [ ] Diarrhea

Endocrine:
- [ ] Hypothyroid
- [ ] Hypoglycemia
- [ ] Hyperthyroid
- [ ] Diabetes Type I
- [ ] Diabetes Type II
- [ ] Night Sweats
- [ ] Unusual Sweating
- [ ] Feeling Hot or Cold

Other:
- [ ] Cancer Type:_______________
- [ ] Fibromyalgia
- [ ] Lupus
- [ ] Candida
- [ ] Anemia
- [ ] Rashes
- [ ] Eczema / Hives
- [ ] Cold Hand / Feet
- [ ] Hemophilia
- [ ] Thin / Graying hair

Liver Conditions:
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C

Men Only:
- [ ] Impotence
- [ ] Vasectomy Date: ______________
- [ ] Prostate problems
- [ ] Testicular Pain / Redness / Swelling
- [ ] Low libido
- [ ] Excessive libido
- [ ] Painful Intercourse
- [ ] Seminal emissions

Women Only:

Are you pregnant right now? [ ] Yes [ ] No [ ] Trying [ ] Maybe Method of Birth Control:_________________

Age at first period: ____________ Date of last menses: __________________ Age at menopause: ______________

Typical length of cycle (days): _________ Number of: Pregnancies: _____ Births: _____ Abortions: _____

Miscarriages: ______ Hysterectomy: [ ] Yes [ ] No Date: _______________

Check all that apply: [ ] Low libido [ ] Excessive libido [ ] Painful Intercourse [ ] Clotting
[ ] Painful Periods [ ] Heavy Flow [ ] Scanty Flow [ ] Bleeding Between Cycles [ ] Irregular Cycles
[ ] Vaginal Discharge [ ] Breast Lumps / Tenderness [ ] Nipple Discharge [ ] Infertility
[ ] Menopausal Symptoms [ ] Premenstrual Problems

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Medications

Please list all prescription and over the counter medications you are currently taking:

Drug Name	Reason for taking	For how long	Dose	Frequency

Please list all supplements and herbs you are currently taking:

Supplement	Reason for taking	Potency	Frequency

Lifestyle

(Daily amount used within the past 2 months)

Tobacco: ☐ Yes ☐ No Amount: ________________ Alcohol: ☐ Yes ☐ No Amount: __________________

Coffee: ☐ Yes ☐ No Amount: _________________ Recreational Drugs: ☐ Yes ☐ No Amount: _________

Do you feel you are at or near your ideal weight? ☐ Yes ☐ No

Do you feel you have enough energy? ☐ Yes ☐ No Are you vegetarian or vegan? ☐ Yes ☐ No

Best time of day: _______________________________ Worst time of day: ___________________________

Favorite Season: _______________________________ Hours of sleep / night: _______________________

Do you feel rested after a nights sleep? ___________________ Do you remember your dreams? ________________

Typical day's meals:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks / Other: ____

Food cravings: ____

Religion or other spiritual practice: ____

Hobbies or other recreation: ____

What kind of physical exercise do you do regularly? ____________________________________

Hours of television watched per week? _________________ Hours of work per week? ______________________

Highest level of education completed? ☐ High School ☐ Bachelors ☐ Masters ☐ Doctorate ☐ Other

How would you rate your current stress level? ☐ Extreme ☐ Very High ☐ High ☐ Moderate ☐ Low

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Emotions / Relationships

Number of biological Brothers: ________ Sisters: ________ Were you adopted? ☐ Yes ☐ No

Did you feel safe and nurtured as a child? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

What would you characterize as your predominate emotion right now? ☐ Anxiety / Worry ☐ Anger ☐ Grief ☐ Fear / Dread ☐ Depression ☐ Melancholy ☐ Happiness ☐ Contentment ☐ Joy ☐ Numbness / Apathy ☐ Other:______________________________

Do you enjoy your work? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

Why or why not? ______________________________

Do you love where you live? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

Why or why not? ______________________________

Do you feel you have a higher purpose for your life? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

Do you feel safe in your current significant relationship(s)? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

Do you feel nurtured in your current significant relationship(s)? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

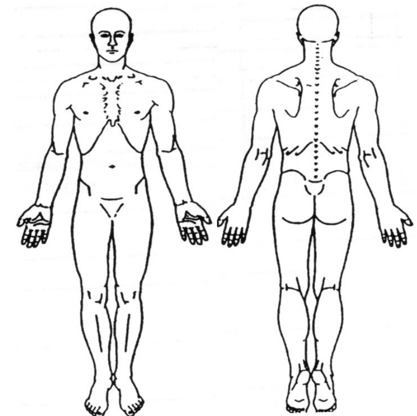
Are you happy with your current significant relationship(s)? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

Are you satisfied with your sex life? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

If you were guaranteed of success and money and time were not obstacles, what would you like to do with your life?_____
____

Please feel free to express any concerns or thoughts you feel may be relevant to your health below:

Use the diagram if desired.______________________________



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The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Red Phoenix Acupuncture 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

X Signed: ______________________________ Date: ______________

Parent / Guardian (if applicable) ______________________________

Would you like to receive a free email newsletter? ☐ Yes ☐ No