

Acupuncture & Herb Center

Marlene Klein, LAc

Facial Questionnaire

Name: _____ **Date:** _____ **Age:** _____ **Sex (M / F)**

Occupation: _____

1) a: Have you ever received facial acupuncture treatment? _____

b: Have you ever received facial non-needle acupuncture treatment? _____

2) How much sun exposure do you get per week? _____

3) What are your major facial concerns? _____

4) What are you hoping to accomplish with Facial Rejuvenation? _____

5) Do you drink 8 glasses of water a day? _____

6) Have you had any facial surgeries? If yes, when was the surgery? _____

Do you have or have you ever had the following: (Please circle all that apply)

Skin type: Normal Dry Combination Oily Sensitive

Skin conditions: Acne Eczema Itching Skin Cancer Skin Rashes Rosacea
Skin Allergies None