Olson Acupuncture Group
Cosmetic Acupuncture Consultation

Name:____ Date:__________________

What areas of your skin are you concerned about?

Fine Lines	Age Spots	Cheeks
Discoloration	Acne	Mouth
Dryness	White bumps on face	Nose
Dull Skin	Forehead	Neck
Jowls/jawline	Between Eyes	Other:____________
Deep Wrinkles	Crow's Feet	_________________
Uneven Skin Tone		______________

What do you *like* about your facial features: ____

Do you suffer from any of the following?

- Migraines
- Seizures
- High Blood Pressure
- Disorders of connective tissue, collagen, or elastin
- Easy bruising

Are you currently or is there a chance you could be pregnant, or are you currently trying or planning to conceive? ☐ Yes ☐ No

Do you take any of the following?

- Blood thinners
- Aspirin
- Fish Oil
- Flax Seed Oil
- Vitamin E

Do you do any of the following?

- Smoke How often? _______________________
- Drink Alcohol? How much, and how often? ___________________________
- Eat Sugar
- Sun tan (now or when younger)

What other procedures have you done?

- Botox
- Fillers/Injectables
- Chemical Peel
- Face lift or other surgery
- Other:____

What skin care products are you currently using?