



## AcuTherapy & Herbal Medicine, LLC

Dear New Patient,

Congratulations on deciding to use the **Mei Zen™ Cosmetic Acupuncture** series as your healthy option for looking and feeling younger. Cosmetic Acupuncture is the only healthy option for cosmetic improvements currently available. It is the “true anti-aging medicine”. Though the procedure is not well known publicized in the United States, Emperors and the wealthy have used it for centuries in China. It is also a modality that has been used in Europe, Korea & Japan for centuries. In matter of fact, the Father of French Acupuncture, Jacques Lavier, created a protocol and incorporated acupuncture facial rejuvenation into practice. I am involved in an educational campaign that will teach you that Cosmetic Acupuncture is a relatively non-invasive procedure that brings about some amazing results that are more than just skin deep. And, it is the only cosmetic procedure that actually improves your health, unlike methods such as plastic surgery or Botox injections that only change the appearance without correcting the underlying imbalances.

The obvious benefits include having softer, firmer skin; reduction of deeper wrinkles; possible elimination of finer wrinkles; and improvement in jowl lines. Although not visually as dramatic as a surgical procedure, Cosmetic Acupuncture actually has a much more dramatic overall effect as we have seen a number of very healthy “side effects” occur. Besides the obvious visual changes, patients have reported improved digestion, better quality sleep, and reduction of hot flashes, elimination of mild depression and anxiety, improved energy, and an overall sense of well-being. So patients leave not only looking younger but also feeling younger and healthier. I think it is fair to say this is the **only cosmetic procedure that actually improves the health of the patient** and that is why I am so passionate about what I do!

From a Western medicine standpoint, Cosmetic Acupuncture works because the needling causes micro-traumas in the skin to which the body responds by increasing blood flow and the production of collagen and elastin for wound healing. The needling, which is done at the level of the dermis, can stimulate neurotransmitter production. From the Traditional Chinese Medicine (TCM) perspective, Qi and Blood are being brought to the face, Qi is being lifted, and the body's energetic systems are being put into balance. This is why wonderful side effects occur. The procedure is very low risk because needling is superficial; occasionally bruising does occur. Besides the needling part of the procedure, we will talk with you about skin care, nutrition, and supplements that help you get and maintain the best results possible. I may also recommend herbal formulas.

The procedure is twelve treatments that are scheduled twice a week for six weeks after an initial consulting treatment to determine if the **Mei Zen™ Cosmetic Acupuncture** is right for you. Cosmetic acupuncture for the abdomen for losing inches and supporting weight loss is also available. This procedure is twice per week for 10 weeks and then once per week for an additional 5 weeks. Treatments last about 90 minutes.

I ask that you complete the following forms as they consist of a number of questions addressing diet, lifestyle, past medical history, and family medical history. They also include consent and release forms. Please take time to fill these out completely. All the answers are important in understanding you as a whole person and will greatly aid in the evaluation of your health conditions. Please allow yourself some time to fill out the paperwork before your visit. Your session will not start with you unless paperwork is complete.

Yours in Health and Wellness,

Wyatt N. LaCoss, MAOM, Dipl.OM, Lic.Ac.  
AcuTherapy & Herbal Medicine, LLC



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Most conditions require an average of 6-12 treatments, although some will respond well within 4-6 visits and others may require a longer series – this depends on the severity and the chronic nature of the chief complaint and how your body individually responds to the treatment.

## ACUPUNCTURE REGISTRATION FORM

Today's Date:

☐ Mr. ☐ Mrs. Name  
☐ Mr. ☐ Dr.

Gender

Date of Birth

Age

Height

Weight

Social Security

Street Address, City, State, Zip Code

Home Phone

Cell Phone

Other Phone

Email

### Best time to reach you

☐ Morning ☐ Evening ☐ Separated ☐ Widowed  
☐ Afternoon ☐ Divorced ☐ Other

### Best phone to reach you

☐ Cell ☐ Home ☐ Work

Have you Been treated by Acupuncture or Oriental Medicine Before?

☐ Yes ☐ No

### How did you hear about our clinic? Whom may we thank?

☐ Yellow Pages ☐ Facebook  
☐ Web Search ☐ Event  
☐ Yelp ☐ Newspaper Coverage  
☐ Clinic Website ☐ Employer  
☐ Magazine ☐ Flyer

### Relationship status

☐ Single ☐ Living ☐ Separated ☐ Widowed  
☐ Married w/Partner ☐ Divorced ☐ Other

### Work Status

☐ Full-Time ☐ Retired ☐ Disabled ☐ Full-Time Student  
☐ Part-Time ☐ Unemployed ☐ Part-Time Student

Last Treatment

☐ Other (please specify)

☐ PCP (Name and Address)

☐ Current Patient / Word of Mouth Referral:

### PRIMARY CARE PHYSICIAN

Physician Name

Physician Address

Physician Phone #

Physician Fax

Signature of Patient or Authorized Representative

Printed Name and Relation

### RELEASE OF INFORMATION AND EMERGENCY CONTACT

Contact Name

Relationship

Street Address

City, State, Zip Code

Home Phone #

Cell Phone #

Email

Date

## NEW PATIENT INFORMATION, COSMETIC AND FACIAL REJUVENATION ACUPUNCTURE

Your first visit will last about 2 hours. Follow-up treatments will take 90 minutes. Acupuncture has been practiced for centuries, but may be very different from any health care experience you have ever had. I will ask you a number of questions about your health and history that are unfamiliar, and you may never have had a health intake that included looking at your tongue and taking your pulses. It will only be unfamiliar the first time! I encourage you to ask me questions about your treatment and progress. Your treatment is individual, as is your response to it. By asking questions you are learning how your own body heals.

### **Cosmetic Results to expect:**

- A "leveling" of deep lines. Deeper lines may never go completely away but they can "fill up" and look much softer, less harsh
- The beginnings of jowls can be minimized. The Mei Zen technique will not make a waddle under the neck go away, but it will definitely define the jaw like in women who are just starting to get saggy there
- Cheeks get smoother
- People see improvement in acne and rosacea
- Skin gets softer, more vibrant
- A reduction in fine lines...they may even disappear
- Overall skin tone becomes more consistent...if your face has lots of red in it, this technique may reduce it
- Age spots have faded
- Those "little hard spots on my face went away"
- Wrinkles on the décolletage have disappeared-those vertical lines that some women get as a result of sun damage

### **"Side Effects" to expect:**

- Hot flashes and/or night sweats go away
- Mild anxiety is resolved
- Many cosmetic acupuncture patients report that their digestion is improved and this will definitely affect what is going on in the skin and on the face
- Eyes look bright, to TCM Practitioners this means that the Shen (Spirit) is balanced
- Patients report having more energy
- "I had a headache when I came in but it was gone when I left!"

### **Vitamins and minerals to take internally**

- Vitamin A: no more than 5000 IU as it can accumulate and become toxic. Best to take it in its precursor form + beta carotene
- B-Complex: B-6 is especially important in protecting your skin. No more than 50-100 mg/day.
- Vitamin C: 1000 mg. Over 50 take 3000-5000 mg/day or as bowels will tolerate
- Vitamin E: 200 IU/day (or some say more). Alpha tocopherol succinate is the important type to take. Vit.E taken internally is good for the tone of facial muscles (among lots of other uses) It can also be used topically
- Co-Enzyme Q10: antioxidant very easily depleted and therefore must be replenished; protects cells from free radical damage. 30-100 mg/day

### **Food and your skin**

- Food is medicine... it's a very natural way to improve your health
- Olive oil-oleic acid keeps the skin soft and smooth by reducing micro-inflammation that causes wrinkling and sagging
- Green tea helps prevent sun damage
- Tomatoes, especially cooked tomato products, contain lycopene which scavenges free radicals that cause aging
- Honey and eggs help reduce dryness. Actually you can make a nice mask out of egg whites and olive oil or egg yolks with honey
- Drink PLENTY of water
- Cherries benefit skin (and are said to prolong life!)
- Eat plenty of foods that are rich in antioxidants including citrus fruits, berries, watermelon, papaya, orange or red veggies, broccoli, egg yolks, almonds, salmon and flax seeds

## Topicals

- Vitamin C Ester: This is essential to the production of collagen and it hinders the inflammation process that can be a cause of free radicals. It also provides protection to the cell wall where free radicals attack
- Alpha Lipoic Acid: is the Universal antioxidant and is great for the skin. It fights free radicals in any part of the cell as well as between the cells. It speeds up repair process in cells. It is particularly helpful for lines and wrinkles, under eye bags and puffiness, enlarged pores, acne scars, and for helping make the skin less dull
- DMAE: dimethylaminoethanol is an antioxidant membrane stabilizer by becoming part of the cell plasma membrane enabling the membrane to resist stress. Safe to use –it is taken internally and is considered a food grade substance. It is particularly good for loss of firmness in the skin; fine lines above and below the lips; and stressed, overtired skin
- Alpha and beta hydroxyl: exfoliates, good to use on rough unevenly pigmented skin. It enhances the penetration of Ester C and alpha Lipoic Acid

## Helpful Hints

- Moisturize, moisturize, moisturize-apply moisturizer to damp skin (it both brings moisture to the skin and helps trap the moisture that's already on the skin) \*\*\*\*\*especially at night when cellular repair speeds up.

## TO PREPARE FOR YOUR FIRST VISIT PLEASE REVIEW THE FOLLOWING:

### 1. Complete Health History Questionnaire

- a. Please print and complete the Registration and Health History Questionnaire and bring it with you.
- b. This questionnaire will form the basis of an in-depth conversation we'll have at your initial consultation and enable me to customize an effective treatment plan for you.

### 2. What to Wear

- a. Please wear loose-fitting, comfortable clothing that is convenient for accessing areas such as the arms, legs, abdomen and back of the body during treatments.
- b. Please refrain from wearing any perfume, cologne or scented lotions.

### 3. What Not to Eat/Drink

- a. Eat a light meal prior to your appointment to prevent any possible light headedness or nausea
- b. Don't drink caffeinated beverages (coffee, tea, energy drinks, etc.) or take any pain medications for at least 4 hours prior to your visits.
- c. Don't eat or drink anything that changes the color of your tongue, and don't brush your tongue the morning of your appointments. In Chinese medicine, the tongue gives us valuable information about your health.

### 4. Before Treatment

- a. For your first visit, please arrive 15 minutes prior to your scheduled appointment time to make sure all paperwork is completed, so we can get your treatment started right away
- b. Bring a list of any medications, supplements, or herbs, etc. that you are currently taking.
- c. Stop aspirin and additional doses of Vitamin E for 2 weeks prior to reduce potential for bruising (unless you have been advised by your physician to take additional Vitamin E or aspirin. Then please talk with him or her about it.
- d. One hour before: no hot showers, hot tub, sauna etc.
- e. Remove contact lenses and **do not wear make-up to the treatments** (greasy substances have insulating properties that might block the energetic manipulation) and your skin should be clean. Eye makeup is okay, but be prepared to remove make-up prior to treatment.
- f. Don't wear sunscreen before, **but do wear sunscreen after the treatments**
- g. Please use the restroom prior to your appointment.

### 5. After Treatment

- a. Allow time to RELAX as much as possible. Ideally go home and relax for several hours. It's important to give your body a chance to fully-integrate the treatment, so don't plan on going to the gym or doing any kind of strenuous exercise after you leave the clinic.
- b. Don't eat heavy/greasy meals, use drugs of any kind or drink alcohol for at least 6 hours after your acupuncture treatments

# Health History For Facial Rejuvenation Acupuncture

Today's Date: \_\_\_\_\_

Name \_\_\_\_\_

Gender \_\_\_\_\_

Age \_\_\_\_\_

Date of Birth \_\_\_\_\_

Street Address, City, State, Zip Code \_\_\_\_\_

**This is a confidential record of your medical history and will be kept in this office. The information it contains will not be released to any person without your authorization**

## CONTACT INFORMATION

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Other Phone \_\_\_\_\_

Email \_\_\_\_\_

Occupation \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

Have you Been treated by Acupuncture or Oriental Medicine Before?

☐ Yes  
☐ No

Last Treatment \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

## EMERGENCY CONTACT

Contact \_\_\_\_\_

Phone # \_\_\_\_\_

Relationship \_\_\_\_\_

Physician Name \_\_\_\_\_

Physician Address \_\_\_\_\_

Physician Phone # \_\_\_\_\_

Relationship status \_\_\_\_\_

☐ Single  
☐ Married  
☐ Living w/Partner  
☐ Separated  
☐ Divorced  
☐ Widowed  
☐ Other

## MAIN CONCERNS

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

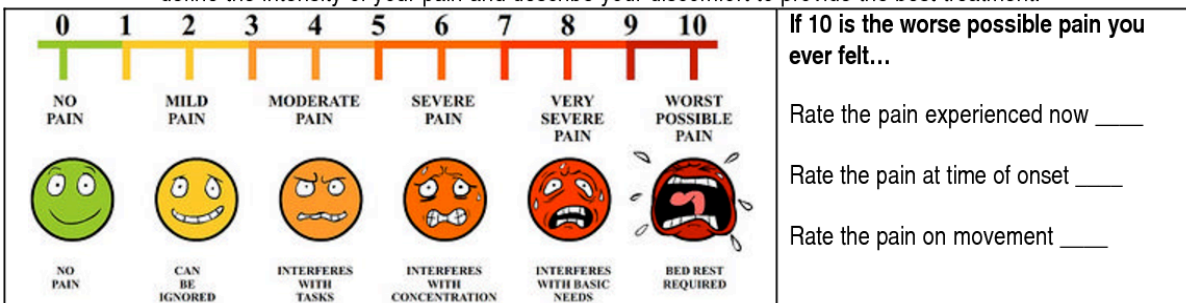
When did this start? \_\_\_\_\_

## OTHER HEALTH CONCERNS

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Use the scale below to better estimate the level of the pain you are experiencing:**

Remember that pain affects everyone differently and only you know how you feeling. The following scale can help you define the intensity of your pain and describe your discomfort to provide the best treatment.



**If 10 is the worst possible pain you ever felt...**

Rate the pain experienced now \_\_\_\_\_

Rate the pain at time of onset \_\_\_\_\_

Rate the pain on movement \_\_\_\_\_

Heat makes it:  
Cold makes it:

☐ Better  
☐ no change  
☐ worse

Damp makes it:  
 Exercise makes it:

☐ Better  
☐ no change  
☐ worse

## HEALTH HISTORY

	You	Year	Family		You	Year	Family
<input type="checkbox"/> Cancer – type(s)				<input type="checkbox"/> Allergies – Types			
<input type="checkbox"/> Osteoporosis				<input type="checkbox"/> Stroke			
<input type="checkbox"/> Diabetes				<input type="checkbox"/> Alcoholism			
<input type="checkbox"/> Herpes				<input type="checkbox"/> Seizure			
<input type="checkbox"/> Hepatitis				<input type="checkbox"/> Thyroid Disease			
<input type="checkbox"/> Aids/HIV				<input type="checkbox"/> Mental Illness			
<input type="checkbox"/> High Blood				<input type="checkbox"/> Asthma			
<input type="checkbox"/> Pressure				<input type="checkbox"/> Kidney Disease			
<input type="checkbox"/> Other STD				<input type="checkbox"/> Pacemaker			
<input type="checkbox"/> Heart Disease				<input type="checkbox"/> Anemia			
<input type="checkbox"/> Rheumatic Fever							

## HABITS

	Amount	Frequency
<input type="checkbox"/> Coffee/Tea	_____	_____
<input type="checkbox"/> Tobacco	_____	_____
<input type="checkbox"/> Alcohol	_____	_____
<input type="checkbox"/> Drugs	_____	_____

## EXERCISE

Regularly?      If so, what and How Often

☐ Yes

☐ No      \_\_\_\_\_

\_\_\_\_\_

How is your energy level?      \_\_\_\_\_

When is it lowest?      \_\_\_\_\_

When is it highest?      \_\_\_\_\_

## **MEDICATIONS**

Please note what medications, herbs or supplements you use regularly

[illegible]

## INJURIES & SURGERIES

Please note area of body & date

Area of Body	Date

## TEMPERATURE

How warm / cold you feel (not in degrees) relative to other people?

Do you wear more or less layers, etc.

Please indicate your body's overall relative Temperature Along The Line With An X

**COLD** ←————→ **HOT**

<input type="checkbox"/> Cold hands/ feet	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Hot hands, feet, chest
<input type="checkbox"/> Chills	<input type="checkbox"/> Thirst for cold /hot drinks	<input type="checkbox"/> Unusual sweats	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Cold “in the bones”	<input type="checkbox"/> Thirst, no desire to drink	When? _____ am / pm	<input type="checkbox"/> Hot in afternoon
<input type="checkbox"/> Areas of numbness	<input type="checkbox"/> Absence of thirst	Where on body _____	<input type="checkbox"/> Hot at night

## MOISTURE

Please indicate your body's relative moisture level along the line with an X  
Hair, skin, mouth, etc.

← DRY				OILY →
<input type="checkbox"/> Dry skin	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Edema /Swelling	<input type="checkbox"/> Weight gain / loss	
<input type="checkbox"/> Dry hair	<input type="checkbox"/> Dry lips	<input type="checkbox"/> Rashes	<input type="checkbox"/> Oily skin	
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Dry throat	<input type="checkbox"/> Itching	<input type="checkbox"/> Oily hair	
<input type="checkbox"/> Dry brittle nails	<input type="checkbox"/> Dry nose /Nosebleeds	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Pimples	

## DIGESTION

Please indicate your body's overall digestion along the line with an X

← DIARRHEA				CONSTIPATION →
BM: How often? _____ x / every _____ days	<input type="checkbox"/> Belching	<input type="checkbox"/> Dry Stools	<input type="checkbox"/> Poor appetite	
<input type="checkbox"/> Alternating diarrhea & constipation (IBS)	<input type="checkbox"/> Bloating	<input type="checkbox"/> Difficult to pass	<input type="checkbox"/> Ulcer	
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Nausea / Vomiting	<input type="checkbox"/> Tired after BM	<input type="checkbox"/> Hemorrhoids	
<input type="checkbox"/> Gas	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Excessive hunger		

## ENERGY

Please indicate your body's overall energy level along the line with an X

← LOW				HIGH →
<input type="checkbox"/> Sudden energy drop	<input type="checkbox"/> Dependence on caffeine	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Hard to concentrate	
<input type="checkbox"/> Time of day: am / pm	<input type="checkbox"/> Wired / ungrounded feeling	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Poor memory	
<input type="checkbox"/> Energy drop after eating	<input type="checkbox"/> Body/ Limbs feel heavy	<input type="checkbox"/> Blood pressure High / Low	<input type="checkbox"/> Dizziness / lightheaded	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Body / Limbs feel weak	<input type="checkbox"/> Bleed / Bruise easily	<input type="checkbox"/> Headaches _____x / week	

## FEMALE REPRODUCTIVE

Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No	# of births _____ Premature _____ Miscarriages _____ Abortions	<input type="checkbox"/> Changes in body/psyche prior to menstruation (PMS) <input type="checkbox"/> Cramps Before bleeding	MENOPAUSE Age changes began _____ Age at last menses _____
MENSES Age at first menses _____ Length of full cycle _____ days Length of menses _____ days Last menses start date _____ / _____ # of pregnancies _____	<input type="checkbox"/> Birth control pill (hormonal) <input type="checkbox"/> Heavy periods <input type="checkbox"/> Light periods <input type="checkbox"/> Painful periods <input type="checkbox"/> Irregular periods	_____ First day _____ During period <input type="checkbox"/> Fatigue w/ menses <input type="checkbox"/> Digestive changes w/ menses <input type="checkbox"/> Mid-cycle spotting <input type="checkbox"/> Yeast infections	<input type="checkbox"/> Hot flashes _____x/ day <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Night sweats _____x/ week <input type="checkbox"/> Loss of sex drive

## MALE REPRODUCTIVE

Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Premature ejaculation <input type="checkbox"/> Sores on genitals <input type="checkbox"/> Discharge	<input type="checkbox"/> Prostate disease <input type="checkbox"/> Genital Pain <input type="checkbox"/> Jock Itch	<input type="checkbox"/> Vasectomy <input type="checkbox"/> Hernia <input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Change of sexual drive <input type="checkbox"/> Erectile dysfunction			

## EMOTIONS

What emotion(s) dominate your experience?

<input type="checkbox"/> Anger	<input type="checkbox"/> Worry	<input type="checkbox"/> Grief	<input type="checkbox"/> Timid / shy
<input type="checkbox"/> Irritability	<input type="checkbox"/> Obsessive thinking	<input type="checkbox"/> Depression	<input type="checkbox"/> Indecision
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Sadness	<input type="checkbox"/> Fear	

## URINARY (if applicable)

<input type="checkbox"/> Decrease in flow	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Cloudy urine
<input type="checkbox"/> Dribbling	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Difficulty starting / stopping	<input type="checkbox"/> Urgency to urinate	<input type="checkbox"/> Burning sensation	

## SLEEP (if applicable)

# hours per night _____	<input type="checkbox"/> Wake _____x/ night @ _____ am / pm	How often? _____	<input type="checkbox"/> Restless sleep
<input type="checkbox"/> Difficulty falling asleep	<input type="checkbox"/> Wake to urinate	<input type="checkbox"/> Disturbing dreams	<input type="checkbox"/> Not rested upon waking

## HEAD, EYES, EARS, NOSE, THROAT

<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Sinus congestion	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Night Blindness	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Excess earwax	<input type="checkbox"/> Headache	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Spots in front of eyes
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Migraine	<input type="checkbox"/> Phlegm (color _____ )	<input type="checkbox"/> Dental problems
<input type="checkbox"/> Frequent Coughs	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Red eyes	<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Jaw Problems /TMJ
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Teary Eyes	<input type="checkbox"/> Teeth Grinding
<input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Dry Eyes	

# COSMETIC AND FACIAL REJUVENATION ACUPUNCTURE

Name \_\_\_\_\_

Today's Date: \_\_\_\_\_

## THREE MAIN CONCERNS

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please describe any skin sensitivities or allergies: \_\_\_\_\_

Do you suffer from any bleeding or clotting disorders? \_\_\_\_\_

☐ Yes ☐ No

If yes, please describe: \_\_\_\_\_

Do you bruise easily? \_\_\_\_\_

☐ Yes ☐ No

Have you recently, or are you currently taking any blood-thinning substances (pharmaceutical or natural)? \_\_\_\_\_

☐ Yes ☐ No

If yes, please list with dosages: \_\_\_\_\_

## CURRENT BEAUTY ROUTINE

Please include brand name

Cleanser \_\_\_\_\_

Toner \_\_\_\_\_

Moisturizer \_\_\_\_\_

Masks \_\_\_\_\_

Do you wear makeup daily? \_\_\_\_\_

☐ Yes ☐ No

Do you use sunscreen? \_\_\_\_\_

☐ Yes ☐ No

Do you go to tanning booths? \_\_\_\_\_

☐ Yes ☐ No

Do you participate in vigorous aerobic activity or sport? \_\_\_\_\_

☐ Yes ☐ No

Have you had facelift surgery? \_\_\_\_\_

☐ Yes ☐ No

If so ...

☐ Full ☐ Partial

Do you get facial waxing / electrolysis / or use depilatories? \_\_\_\_\_

☐ Yes, wait approximately 5 days between treatments

☐ No

If you have had facelift surgery ...

When \_\_\_\_\_ / \_\_\_\_\_

Where: \_\_\_\_\_

If you have had facelift surgery, were you satisfied? \_\_\_\_\_

☐ Yes ☐ No

Please elaborate \_\_\_\_\_

Type

## FACIAL TREATMENTS

Date(s)

- ☐ Microdermabrasion
- ☐ Chemical Peels
- ☐ Silicon injections
- ☐ Rhytidectomy

- ☐ Photolight Rejuvenation
- ☐ Restalyne
- ☐ Mesotherapy
- ☐ Blepharoplasty

- ☐ Retin-A
- ☐ Botox Injections
- ☐ Laser procedures
- ☐ Brow or Coronal Lift

- ☐ Collagen Injections
- ☐ Renova
- ☐ Threading (Lift)

- ☐ Acne or Acne Scars
- ☐ Age Spots
- ☐ Aging skin
- ☐ Blemishes
- ☐ Broken Capillaries
- ☐ Brown Spots
- ☐ Bunny Lines
- ☐ Cancer
- ☐ Capillaries
- ☐ Dehydration

- ☐ Dry Skin
- ☐ Dullness / Dull, aged skin
- ☐ Eczema
- ☐ Enlarged Pores
- ☐ Environmental damage
- ☐ Facial Redness
- ☐ Fine Lines
- ☐ Herpes
- ☐ Horizontal Forehead Lines / Frown / Worry Wrinkles

## SKIN

- ☐ Lusterless Skin
- ☐ Marionette Lines / Mouth Frown
- ☐ Mental Crease
- ☐ Muscle Weakness
- ☐ Oily skin and acne
- ☐ Prominent veins
- ☐ Psoriasis
- ☐ Puffy / Swollen
- ☐ Rashes
- ☐ Rosacea (Redness)

- ☐ Sagging skin
- ☐ Sallow (Yellow)
- ☐ Scarring
- ☐ Scowl Lines / Glabella Lines / Furrows / Vertical Creases
- ☐ Sties
- ☐ Sun Damage
- ☐ Tear Troughs
- ☐ Vertical Lip Lines / Oral Commissures
- ☐ Warts

- ☐ Dark Eye Circles
- ☐ Bags/Swelling Under Eyes

- ☐ Under Eye Bags
- ☐ Brow Droop / Low Eyebrow / Droopy Eye Lids / Lateral Hoods

## EYES

- ☐ Crow's Feet / Periorbital Lines / Smoker's Smile

- ☐ Puffy Upper Lids

- ☐ Crêpe-y skin
- ☐ Double Chin

- ☐ Jaw Contours
- ☐ Wrinkles

## NECK

- ☐ Sagging Skin At Neck (Jowls)

- ☐ Turkey Neck / Waddle

- ☐ Crackling
- ☐ Cold Sores

- ☐ Smoker's Wrinkles
- ☐ Nasolabial Fold / Laugh-Smile Lines

## LIPS/MOUTH

- ☐ Protruding Temporal Veins

- ☐ Lip Thinning

- ☐ Thin Hair
- ☐ Alopecia (baldness)
- ☐ Excess Facial Hair

## HAIR

Hair follicle treatments?

☐ Yes ☐ No

If so, When? \_\_\_\_\_ / \_\_\_\_\_

Electrolysis treatments:

☐ Yes ☐ No

If so, When? \_\_\_\_\_ / \_\_\_\_\_

Thank You for Taking the Time to Complete Prior to Your First Treatment



**FOREHEAD / TEMPLE:**

Loss in Fat in Forehead  
 Prominence of Transverse Forehead Lines - Frown Lines - Worry Lines - Forehead Lines  
 Superficial Lines Around the Forehead and Temple Area  
 Temple Lines

**EYES:**

Crow's Feet  
 Dark Circles  
 Superficial Lines Around the Eyes  
 Under Eye Bags  
 Under Eye Circles  
 Vertical Length of Lower Lid

**EARS:**

Ear Lobes Lengthen  
 Ear Wrinkles  
 Skin Stretches and Sags

**CHEEKS:**

Greater Visibility of Bony Landmarks, Lines and Wrinkles  
 Hollowing of the Mid-Face (Loose Skin) - Loss in Fat in Cheeks  
 Pallor (aka Pale Skin)

**NOSE:**

Droops  
 Nasolabial Folds Become More Prominent - Smile Lines (Nasolabial Folds, Lines From Nose to Mouth)

**CHIN / JAW:**

Chin Wrinkle  
 Double  
 Fat Gain in Jaw  
 Jaw Contours

**LIPS / MOUTH:**

Development of Pre-Jowl Depression (Marionette Lines - Lines From Corners of Mouth to Jaw)  
 Dry Skin  
 Fat Gain in Mouth  
 Laugh Lines  
 Lip Flattening  
 Loss of Volume - Lip Thinning  
 Smokers Wrinkles  
 Vermilion Border (Lip Border Diminishes with Age Causing Lipstick Bleed)  
 Vertical Lip Lines

**NECK:**

Brown Spots and Pigmentation  
 Loose Skin / Sagging Skin (Turkey Neck)  
 Necklace Lines  
 Prominent Neck Cords  
 Red, Blotchy areas  
 Thin Skin

**SKIN:**

Acne Scars  
 Broken Capillaries  
 Facial Hair  
 Facial Redness / Veins  
 Facial Volume Loss  
 Freckles and Brown Age Spots  
 Itching Skin  
 Large Pores / Facial Texture  
 Less Elastic Skin  
 Muscle Weakness  
 New Moles  
 Pebble  
 Problems with Healing  
 Problems with Scarring (Hypertrophic or Keloid)  
 Rash  
 Acne Scars  
 Birthmarks  
 Post-Surgical Scars  
 Rosacea  
 Rough Texture  
 Sagging Skin  
 Significant Change in Existing Moles  
 Spider Veins on Nose, Face  
 Sun Damage  
 Thin Skin



Current s/sx: \_\_\_\_\_

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

Extraordinary Vessels: \_\_\_\_\_

Acupuncture Points: \_\_\_\_\_

Chinese Herbal Medicine: \_\_\_\_\_

Lifestyle Recommendations: \_\_\_\_\_



# AcuTherapy & Herbal Medicine, LLC

## PROTECT YOUR HEALTH INFORMATION AND PRIVACY

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

***Safeguards in place at our office include:***

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

***Types of information that we gather and use:***

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at (617) 694-9415.

Yours in Health and Wellness,

Wyatt N. LaCoss, MAOM, Dipl.OM, Lic.Ac.  
AcuTherapy & Herbal Medicine, LLC



# AcuTherapy & Herbal Medicine, LLC

## "NOTICE OF PRIVACY POLICIES"

I consent to the use or disclosure of my identifiable health information by AcuTherapy & Herbal Medicine (hereafter noted as "AcuTherapy") for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. AcuTherapy is not required to agree to the restrictions that I may request. However, if AcuTherapy agrees to a restriction that I request, the restriction is binding upon AcuTherapy.

I have the right to revoke this consent, in writing, at any time except to the extent that the Recipients have taken action in reliance on this consent.

*My identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review AcuTherapy's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of AcuTherapy. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and AcuTherapy & Herbal Medicine with respect to my identifiable health information.

AcuTherapy & Herbal Medicine, LLC reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

Signature of Patient or Authorized Representative

Date

Printed Name and Relation



# AcuTherapy & Herbal Medicine, LLC

## AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. This clinic does not offer reimbursement for records received.

Please **obtain** information **from** the following:

Name of Physician

Name of Clinic / Hospital

Street Address

City, State, Zip Code

Please **send** my medical information to:

Name of Person to Receive Information

Wyatt N. LaCoss, Lic.Ac.

**AcuTherapy & Herbal Medicine, LLC**

1016 Massachusetts Avenue #1

Arlington, MA 02476

(617) 694-9415

[www.acuthrapyworks.com](http://www.acuthrapyworks.com)

By **checking** the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information **going back one year**. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

☐ Medical records needed for continuity of care

☐ Laboratory reports

☐ Other:

☐ Diagnostic imaging reports

☐ Pathology reports

Date

Patient Signature

Signature of Parent / Guardian if Applicable

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By **signing** the spaces below, I specifically authorize the release of the following confidential information for us by Acupuncture & Associated Therapies. I also authorize the above physician / clinic / hospital to provide the following information via telephone consultation:

☐ Medical records needed for continuity of care

☐ Laboratory reports

☐ Other:

☐ Diagnostic imaging reports

☐ Pathology reports

Patient Signature

HIV/AIDS test results and related information, including high risk behavior documentation. **This information may not be further disclosed without the specific written authorization of the tested individual.**

Patient Signature

Drug/Alcohol diagnosis, treatment, or referral information. Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Please provide a description of this information:

Patient Signature

Mental Health treatment information

Office use only:

Date sent:

Initials:



# AcuTherapy & Herbal Medicine, LLC

## CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

***I understand that this information serves as:***

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

***I understand that I have the right:***

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

***I request the following restrictions to the use of disclosure of my health information:***

Patient Signature or Legal Representative

Date

Witness Signature

**Office use only:**

- ☐ Accepted  
☐ Denied

Signature:

Title:

Date:

## INFORMED CONSENT FOR COSMETIC AND FACIAL REJUVENATION ACUPUNCTURE

**INSTRUCTIONS:** This is an informed consent document that has been prepared to help your acupuncturist inform you concerning facial acupuncture treatments, the risks involved and possible alternatives. Please be advised that this is not a surgical procedure. It is important that you read this information carefully and completely and have all of your questions answered before signing the consent below.

**INTRODUCTION:** An acupuncture facial treatment involves the insertion of acupuncture needles into fine lines and wrinkles on the face and neck in order to reduce the visible signs of aging. In Oriental medicine, the meridians or pathways of Qi (energy) flow throughout the entire body from the soles of the feet up to the face and head; consequently, a facial acupuncture treatment addresses the entire body constitutionally, and is not merely "cosmetic." An acupuncture facial involves the patient in an organic, gradual process that is customized for each individual. It is no way analogous to, or a substitute for, a surgical "face lift." A treatment session may confine itself solely to facial acupuncture, or it may be used in conjunction with other procedures.

**BENEFITS:** Facial acupuncture can increase facial tone, decrease puffiness around the eyes, as well as bring more firmness to sagging skin, enhance the radiance of the complexion and flesh out sunken areas. Customarily, fine wrinkles may disappear, and deeper ones may be reduced. This treatment is not merely confined to the face, but incorporates the entire body and constitutional issues of health.

**ALTERNATIVE TREATMENT:** Improvement of sagging skin, wrinkles and fatty deposits may be attempted by other treatments or surgery such as a surgical facelift, chemical face peels or liposuction. Risk and potential complications are associated with these alternative forms of treatment.

**RISKS OF AN ACUPUNCTURE FACIAL:** Every procedure involves a certain amount of risk and it is important that you understand the risks involved with an acupuncture facial. An individual's choice to undergo an acupuncture facial is based upon the comparison of the risk to potential benefit. Although the majority of patients do not experience the following complications, you should discuss each of them with your acupuncturist to make sure you understand the risks, potential complications and consequences of an acupuncture facial.

**BLEEDING:** It is possible, though very unusual, that you may have problems with bleeding during an acupuncture facial. Should post-acupuncture bleeding occur, it will usually only consist of a few drops. Accumulations of blood under the skin may cause a bruise or hematoma, which will resolve itself.

**INFECTION:** Infection is very unusual after an acupuncture facial. Should an infection occur, additional treatment, including antibiotics, may be necessary.

**DAMAGE TO DEEPER STRUCTURES:** Deeper structures such as blood vessels and muscles are rarely damaged during the course of a facial acupuncture treatment. If this does occur, the injury may be temporary or permanent.

**ASYMMETRY:** The human face is normally asymmetrical. Thus, there can be a variation from one side to the other in the results attained from a facial acupuncture treatment.

**BRUISING AND PUFFINESS:** There is a possibility of bruising, puffiness, blood, tingling, itching, warmth, pain or other symptoms at the site of the needle.

**NERVE INJURY:** Injuries to the motor or sensory nerves rarely result from facial acupuncture treatments. Nerve injuries may cause temporary or permanent loss of facial movements and feeling. Such injuries may improve over time. Injury to sensory nerves of the face, neck and ear regions may cause temporary or, more rarely, permanent numbness. Painful nerve scarring is very rare.

**NEEDLE SHOCK:** Needle shock is a rare complication after an acupuncture facial.

**ALLERGIC REACTIONS:** In rare cases, local allergies to topical preparations have been reported. Systemic reactions which are more serious may occur to herbs used during an acupuncture facial. Allergic reactions may require additional treatment.

**DELAYED HEALING:** Delayed wound healing or wound disruptions are rare complications experienced by patients in the aftermath of an acupuncture facial. There is a greater risk for smokers, who frequently have dry, sagging skin, which does not heal as readily as that of non-smokers.

**LONG-TERM EFFECTS:** Subsequent alterations in facial appearance may occur as the result of the normal process of aging, weight loss or gain, sun exposure, or other circumstances not related to an acupuncture facial. An acupuncture facial does not arrest the aging process or produce permanent tightening of the face and neck. Future facial acupuncture maintenance treatments, or other treatments, may be necessary to maintain the results of an acupuncture facial.

**ADDITIONAL CARE NECESSARY:** There are many variable conditions in addition to risk and potential complications that may influence the long term result from acupuncture facial treatments. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with an acupuncture facial treatment. Other complications and risks can occur but are even more uncommon. Should complications occur, other treatments may be necessary.

**LIABILITY WAIVER:** The practice of acupuncture is not an exact science. Although good results are expected, there is no guarantee or warranty, either expressed or implied, on results that may be obtained.

Consent for Facial Acupuncture Procedure or Treatment

1. I hereby authorize AcuTherapy & Herbal Medicine, LLC to perform a facial acupuncture procedure. I have received a copy of the Informed Consent for Acupuncture Facial for my records.
2. I recognize that during the course of the acupuncture facial, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above acupuncturist and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my acupuncturist at the time the procedure is begun.
3. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from an acupuncture facial. In addition, potential problems that might occur during recuperation have been explained to me.

Signature of Patient or Authorized Representative

Date

Printed Name and Relation