PATIENT INFORMATION FORM FOR FACIAL REJUVENATION ACUPUNCTURE AND MICRONEEDLING:

Client Name_____ Date_____
Address:_____
Phone HM:_____ Wk Phone:_____ Cell:_____
Email:_____(information kept private)
Emergency Contact/Phone: _____/_____
Date of Birth____/____/____ Age:_____ Gender: M / F
Occupation:_____ Marital Status:_____
How did you hear about us? _____

Because this is a holistic approach to healthcare, it is important for the practitioner to have a complete understanding of the patient; physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible, and print all information. If there is confusion on any area of the form, indicate with a question mark.

COSMETIC FACIAL REJUVENATION ACUPUNCTURE:

What is your daily skin care routine?

_____

_____

What changes in your appearance and skin would you like to see happen?

_____

_____

When did your primary concern begin?_____
What about your skin and appearance is working for you? _____

_____

For best results a series of 10-15 Facial Rejuvenation Acupuncture treatments 2 x week, and/or 6 Microneedling treatments 1 x month is recommended, followed by monthly and seasonal maintenance treatments. Understand that results vary depending on health history, lifestyle, age and commitment to the frequency of treatments and lifestyle changes, including: diet, exercise, herbal and supplemental intake and home skin care regime.

- ☐ Hyperpigmentation
- ☐ Wrinkles
- ☐ Crows Feet
- ☐ Nasal Labial Groove
- ☐ Double Chin
- ☐ Sagging/drooping, where:_____
- ☐ Acne/Breakouts
- ☐ Scarring
- ☐ Couperose/ Rosacea
- ☐ Uneven skin tone
- ☐ Enlarged Pores
- ☐ Dry Skin
- ☐ Oily Skin

Additional Comments:_____

- ☐ Previous Anti-aging treatments, Types/When:

_____

- ☐ Resurfacing treatments in the last month? Type?

_____

- ☐ Botox treatments, When:

_____

- ☐ Plastic Surgery, What Kind/When:

_____

- ☐ Use of Retinol/Accutane/Glycolic in last Month
- ☐ High blood pressure, Is it under control of MD?_____
- ☐ Frequent Migraines, How often? Last occurence?

_____

Additional Comments: _____

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MEDICAL HISTORY: (List any major past illnesses, injuries, surgeries with dates)

_____

_____

SIGNIFICANT FAMILY MEDICAL HISTORY: (List briefly and whom)

_____

_____

ALLERGIES OR SENSITIVITIES: (List foods, drugs, medications, metals or skin care products you are allergic or sensitive to (please include reaction):

_____

_____

_____

LIFESTYLE:

Do you follow a regular exercise program? _____ If so, Please describe:

_____

Relaxation Practice: _____

Sleep habits/hours of sleep per night:_____do you feel rested?_____

Please describe your average daily diet:

Do you typically eat at least three meals per day? Y/ N If not, how many?_____

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks: _____

Drinks: _____

What particular diet or nutritional program do you generally follow? Example: (macrobiotic, vegetarian, meat & potatoes, low carb, etc.)

_____

Do you generally cook your own meals? _____

Please check any of the following habits that apply. Indicate how much and how often you consume them:

Cigarette smoking:_____ Coffee, tea, cola _____

Alcoholic beverages: _____ Recreational substances _____

MEDICATIONS/SUPPLEMENTS (prescribed and over-the-counter), herbs, vitamins and supplements you are currently taking or taken within last two months:

_____

_____

_____

Please put a check next to conditions you have had:

Immunity:
- ☐ Fatigue
- ☐ Chronic Fatigue
- ☐ Slow Healing
- ☐ Chronic Colds/Flu
- ☐ Chronic infections
- ☐ HIV/AIDS
- ☐ Other: _____

Respiratory:
- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pain with Inhalation
- ☐ Pneumonia
- ☐ Difficult Breathing
- ☐ Production of phlegm
- ☐ Frequent respiratory infections
- ☐ Other: _____

GenitoUrinary:
- ☐ Kidney Disease
- ☐ Painful Urination
- ☐ Frequent UTI
- ☐ Frequent Urination
- ☐ Venereal Disease
- ☐ Kidney Stones
- ☐ Urination Difficulty
- ☐ Blood In Urine
- ☐ Night Urination
- ☐ Other:

Head/Eyes/Ears/ Nose/Throat:
- ☐ Vision Problems
- ☐ Eye Pain/strain/ redness/itching
- ☐ Floaters/see spots
- ☐ Blurry Vision
- ☐ Color Blindness
- ☐ Poor Vision
- ☐ Night Blindness
- ☐ Cataracts
- ☐ Glasses/Contacts
- ☐ Tearing/Dryness
- ☐ Dizziness
- ☐ Hearing Problems
- ☐ Ear Ringing
- ☐ Earaches
- ☐ Headaches
- ☐ Migraines
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Facial Pain
- ☐ Frequent sore throats
- ☐ Teeth Grinding
- ☐ TMJ/Jaw Problems
- ☐ Seasonal Allergies
- ☐ Dental Problems
- ☐ Cold Sores
- ☐ Dry Mouth
- ☐ Bleeding Gums
- ☐ Convulsions
- ☐ Insomnia
- ☐ Other: _____

MusculoSkeletal:
- ☐ Muscle Spasms
- ☐ Aches/Pains
- ☐ Numbness/Tingling
- ☐ Edema
- ☐ Excess Sweating
- ☐ Cold Hands/Feet
- ☐ Cold Body Temp
- ☐ Hot Body Temp

GastroIntestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Reduced Appetite
- ☐ Excess Appetite
- ☐ Change in Appetite
- ☐ Belching
- ☐ Acid Reflux
- ☐ Ulcers
- ☐ Epigastric Pain
- ☐ Excessive Gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating
- ☐ Heartburn
- ☐ Abdominal Pain
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Food Cravings
- ☐ Excessive Thirst
- ☐ Gallbladder Problems
- ☐ Liver Disease
- ☐ Hepatitis A/B/C
- ☐ Hemorrhoids
- ☐ Other: _____

Skin/Hair:
- ☐ Itching
- ☐ Hives
- ☐ Eczema
- ☐ Acne
- ☐ Skin Rashes
- ☐ Dry Skin
- ☐ Hair Loss
- ☐ Hair Dry or Brittle
- ☐ Premature Greying
- ☐ Nails Brittle
- ☐ Dandruff
- ☐ Other: _____

Cardiovascular
- ☐ Hypertension/high blood pressure
- ☐ Hypotension/Low Blood pressure Heart
- ☐ Fainting
- ☐ Cold Hands/Feet
- ☐ Swelling of Hands/ Feet
- ☐ Poor Circulation
- ☐ Chest Pain
- ☐ Blood Clots
- ☐ Palpitations
- ☐ Rapid heart beat
- ☐ Irregular heart beat
- ☐ Stroke
- ☐ Heart Murmurs
- ☐ Rheumatic Fever
- ☐ Varicose Veins
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ High Cholesterol ☐
- Other: _____

Emotional:
- ☐ Mood Swings
- ☐ Irritability
- ☐ Nervousness/ restless
- ☐ Stress
- ☐ Panic Attacks
- ☐ Fear
- ☐ Anxiety
- ☐ Sadness
- ☐ Difficult Concentration
- ☐ Forgetfulness
- ☐ Other: _____

Additional Comments on Above: _____

_____

_____

_____

_____

_____

_____

WOMEN'S HEALTH:

First day of last menses: _____ Age of first menses: _____ Typical duration of bleeding: _____ Length of menstrual cycle: _____ Is it regular?: _____ If not, explain: _____ Heavy bleeding or light flow? _____ Clotting? (size, quantity) _____ Color of blood (red, dark red, purple, brown, blackish): _____ Discomfort or pain during periods? _____ Stage of cycle? _____ breast tenderness during menses or ovulation? _____ Premenstrual symptoms? please specify: _____ Spotting between periods? _____ Have been diagnosed with: Fibroids? _____ Cysts? _____ Cervical dysplasia? _____ Pelvic inflammatory disease? _____ Unusual discharge? _____ Type of birth control? _____ How long? _____ Total # of Pregnancies: _____ Number of births: _____ Premature births: _____ Miscarriages: _____ Abortions: _____ Are you pregnant now? Yes / No / Maybe Menopause?: _____ Age of Menopause: _____ Hot flashes? _____ Other Symptoms?: _____ Hormone replacement therapy? _____ Other treatments? _____

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Consent For Treatment - Facial Rejuvenation Acupuncture and Microneedling

I freely choose to undergo Facial Rejuvenation Acupuncture treatments and/or Microneedling with Jodi Holmes (practitioner name), knowing that there are no guaranteed results, and I am free to stop treatment at any time. The goal of these treatments is improvement - not perfection. I understand my results might not be perfect, and the number of treatments necessary may vary. There may be more treatments necessary than I anticipated. There is no guarantee that expected or anticipated results will be achieved. I understand that compliance with recommended Microneedling aftercare guidelines are crucial for healing and prevention of scarring or skin textural changes.

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 Chinese 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.

I understand that while acupuncture and microneedling are generally safe methods of treatment, certain adverse effects may result from treatment. These may be, but are not limited to local bruising (hematomas), puffiness, redness, bleeding, temporary pain or discomfort at the site of the needles during or after the treatment, and in more rare circumstances there are the risks of fainting, infection, damage to blood vessels or nerves. In some circumstances, local allergies to topical preparations have been reported. Systemic reactions which are more serious may occur with herbs used during an acupuncture facial. Allergic reactions may require additional treatment.

With microneedling there may be redness, discomfort and/or swelling, or the sensation of having a sunburn at the area of treatment for a few to several hours after treatment. Additionally, redness may be present for 2-3 days after treatment. There may be an increase or decrease in pigmentation and can take 4-6 months or more to resolve. Loss of pigmented lesions such as freckles may give the appearance of loss of pigment. Small areas of scabbing may occur 2-3 days following the treatment. Infection is possible if proper aftercare guidelines are not followed.

I understand the methods of treatment in the scope of Chinese medicine may include but are not limited to acupuncture, microneedling, cupping, moxibustion (applying heat to acupuncture points of the body), electro-stimulation acupuncture, Tui-Na (Chinese massage), and herbal medicine.

Although noticeable results may be obtained with a single MicroNeedling or Facial Acupuncture treatment; the greatest improvement will be seen after a series of four to six consecutive monthly Microneedling procedures, and ten to fifteen Facial Acupuncture sessions twice per week, or a combination of the two.

I understand the acupuncturist is not providing Western medical care, and I should look to my Western primary care physician (MD) for those services and routine checkups.

I understand I must inform my acupuncturist if I am **Pregnant**, have an **acute cold or flu**, an **acute herpes outbreak**, an **acute allergic reaction**, an **active inflammatory skin condition**, am **using accutane or any related acne medication, high blood pressure, diabetes, severe migraines** , am **HIV positive or have AIDS, cancer, or hepatitis** , as these may have additional risks or contraindications with facial acupuncture and microneedling.

I understand all fees for services are due at the time of service, and I will be charged the full fee for appointments that are cancelled with less than 24 hours notice.

I have read, or have had read to me, and completely understand the risks and benefits of acupuncture treatment, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present treatment and for any future condition(s) for which I seek treatment.

Printed Name:_____

Signature:_____

Date: _____

COLORADO MANDATORY DISCLOSURE STATEMENT

Jodi Holmes
8000 South Lincoln St. #6 Phone: 303-347-1271
Littleton, Colorado 80122

Education and Experience

Jodi Holmes earned her Master of Acupuncture and Oriental Medicine degree from the Colorado School of Traditional Chinese Medicine in December 2021. This 28 month program consists of 2,370 hours of education including 540 hours of clinical practice. She is certified as a Diplomate in Acupuncture and Traditional Chinese Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in December 2021, which includes certification in Clean Needle Technique and became a licensed acupuncturist in Colorado and Iowa in May 2022. She is also certified with EastWest Microneedling, April 2023. Jodi's training includes adjunctive therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy and dietary and lifestyle recommendations.
Jodi received her Bachelor of Science degree in Exercise Science at the University of Iowa in December 1988 and worked in the fitness industry for 20 years. She also received her massage certification from Cottonwood School of Massage in 1999 in Colorado and has been working as a licensed massage therapist for almost 25 years. None of these licenses, certificates or registrations have ever been suspended or revoked.

This clinic complies with the rules and regulations enforced by the Colorado Department of Health, including the proper cleaning and sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule

Microneedling/facial rejuvenation acupuncture (1 ½ hours)	$250 (first appt.)
Microneedling Follow-up treatments (1 hour 15min.)	$225
Intake Consultation and Treatment (1 ½ hours)	$100
Acupuncture Follow-up Treatment (1 hour)	$85
Cupping (30 min.)	$50

Patient's Rights

The patient is entitled to receive information about the methods of therapy, the techniques used and the duration of therapy. The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies (DORA). If you have any comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202.

I have read and understand this document.

Patient's or Guardian's signature: _____ Date:_____

Post-Treatment Patient Instructions for
Integrative Microneedling

1. No makeup, sunscreen or face wash should be used until the morning following treatment. Avoid using hot water on your face and neck.

2. Stay out of direct sunlight for a minimum of 12 hours following treatment.

3. Do not strongly exercise / sweat for about 12 hours following treatment.

4. Drink plenty of pure filtered water over the next few days.

5. Your skin may feel like you have a mild sunburn following microneedling. You can apply a cool compress / ice pack (do not use other topical creams / medications).

6. With shorter needle lengths (0.25mm, 0.5mm) the skin may remain unchanged or exhibit a red glow that will likely be gone by the following morning. With longer needle lengths (1.0mm) the skin might look sunburned for a day or two with potential pinprick scabbing (red dots) and should return to normal by day two or three.

7. It's important to keep your skin hydrated following microneedling. Serums containing hyaluronic acid should be applied twice daily at home to enhance results in-between your microneedling treatments. Avoid using serums or creams with high amounts of Vitamin C or A, and products containing strong, synthetic ingredients for 24 hours following treatment.

8. Discontinue other cosmetic interventions, such as home-use dermarollers with needles longer than .3mm, chemical peels, injections and laser skin resurfacing during your microneedling series. Exceptions are microdermabrasion and dermaplaning, which can be beneficial if performed approximately two weeks before a microneedling treatment. Give your skin time to heal and regenerate.

9. Return for a follow up microneedling treatment in four-six weeks until your series is through, and for maintenance treatments thereafter.
Thank you!