New Patient Information, Facial 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.

To prepare for your first visit please review the following:

1. Complete Health History Questionnaire

- *Prior to your appointment please print and complete the Health History Questionnaire and bring it with you.*
- *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

- *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.*
- *Please refrain from wearing any perfume, cologne or scented lotions. Many of our patients are sensitive to fragrances.*

3. What Not to Eat/Drink

- *Eat a light meal prior to your appointment to prevent any possible light headedness or nausea*
- *Don't drink caffeinated beverages (coffee, tea, energy drinks, etc.) or take any pain medications for at least 4 hours prior to your visits.*
- *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

- *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*
- *Bring a list of any medications, supplements, or herbs, etc. that you are currently taking.*
- *Remove contact lenses, wash face*
- *Please use the restroom prior to your appointment. Acupuncture treatments can stimulate your bladder!*

5. After Treatment

- *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.*
- *Don't eat heavy/greasy meals, use drugs of any kind or drink alcohol for at least 6 hours after your acupuncture treatments.*

Gabrielle Applebaum, Acupuncturist

L.Ac, M.Ac, Dipl.Ac, MTS

Health History For Facial Acupuncture

Date: ____/____/____

Name	Gender	Age	Date of Birth _____/_____/_____
Address	City	State	Zip Code

Phone #
- ☐ Home _____
- ☐ Cell _____
- ☐ Other _____
- email _____

Emergency Contact_____

Contact Phone # _____

Relationship _____

Occupation:	Height _____ Weight _____	Physician Name Physician Address Physician Phone #

Have you been treated by Acupuncture or Oriental Medicine before?

☐No ☐Yes .... Last Treatment _____/_____/_____

Relationship status

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

How did you hear about our clinic?

Main Concerns

When did this start? _____

Pain level- *PLEASE CIRCLE*

Pain Scale

Heat makes it:	Better	no change	worse
Cold makes It	Better	no change	worse
Damp makes it:	Better	no change	worse
Exercise makes it	Better	no change	worse

Other Health Concerns

1

2

3

Health History

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

Habits

Amount/Frequency

Coffee/Tea _____
Tobacco _____
Alcohol _____
Drugs _____

Exercise

Regularly? ☐ Yes ☐ No

If so, what and How Often:
_____

Medications

Please note what medications, herbs or supplements you use regularly

Medicine/Vitamins	Dosage	Reason	How Long?

Injuries & Surgeries

Please note 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

☐ Cold hands/ feet
☐ Chills
☐ Cold "in the bones"
☐ Areas of numbness

☐ Excessive thirst
☐ Thirst for cold /hot drinks
☐ Thirst, no desire to drink
☐ Absence of thirst

☐ Night sweats
☐ Unusual sweats

When? _____*am / pm*
*Where on body*_____

☐ Hot hands, feet, chest
☐ Hot flashes
☐ Hot in afternoon
☐ Hot at night

Moisture

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

DRY ◄——————————————► OILY

☐ Dry skin
☐ Dry hair
☐ Dry eyes
☐ Dry brittle nails

☐ Dry mouth
☐ Dry lips
☐ Dry throat
☐ Dry nose /Nosebleeds

☐ Edema /Swelling_____
☐ Rashes_____
☐ Itching _____
☐ Dandruff

☐ Weight gain / loss
☐ Oily skin
☐ Oily hair
☐ Pimples

Digestion

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

DIARRHEA ◄——————————► CONSTIPATION

BM: How often? _____x / every _____days

- ☐ Alternating diarrhea & constipation (IBS)
- ☐ Indigestion
- ☐ Gas
- ☐ Belching
- ☐ Bloating
- ☐ Nausea / Vomiting
- ☐ Bad breath
- ☐ Dry Stools
- ☐ Difficult to pass
- ☐ Tired after BM
- ☐ Excessive hunger
- ☐ Poor appetite
- ☐ Ulcer
- ☐ Hemorrhoids

ENERGY

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

LOW ◄——————————► HIGH

- ☐ Sudden energy drop
  Time of day: _____ am / pm
- ☐ Energy drop after eating
- ☐ Fatigue
- ☐ Dependence on caffeine
- ☐ Wired / ungrounded feeling
- ☐ Body / Limbs feel heavy
- ☐ Body / Limbs feel weak
- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ Blood pressure High / Low
- ☐ Bleed / Bruise easily
- ☐ Hard to concentrate
- ☐ Poor memory
- ☐ Dizziness / lightheaded
- ☐ Headaches _____x / week

Female Reproductive

Are you sexually active? Y ☐ N ☐

MENSES (If applicable)

Age at first menses _____
Length of full cycle _____ days
Length of menses ____ days
Last menses start date ____ / ____
# of pregnancies ____
# of births ___premature ___Miscarriages
___Abortions

- ☐ Birth control pill (hormonal)
- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation (PMS)
- ☐ Cramps Before bleeding___
  First day___During period___
- ☐ Fatigue w/ menses
- ☐ Digestive changes w/ menses
- ☐ Mid-cycle spotting
- ☐ Yeast infections

MENOPAUSE

Age changes began _____
Age at last menses _____

- ☐ Hot flashes _____x/ day
- ☐ Vaginal dryness
- ☐ Night sweats _____x / week
- ☐ Loss of sex drive

Male Reproductive

Are you sexually active? Y ☐ N ☐

- ☐ Change of sexual drive
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Sores on genitals
- ☐ Discharge
- ☐ Prostate disease
- ☐ Genital Pain
- ☐ Jock Itch
- ☐ Vasectomy
- ☐ Hernia
- ☐ Hemorrhoids

Emotions

What emotion(s) dominate your experience?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Fear
- ☐ Timid / shy
- ☐ Indecision

Urinary (if applicable)

- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Difficulty starting / stopping
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Burning sensation
- ☐ Cloudy urine
- ☐ Blood in urine

Sleep

hours per night _____

- ☐ Difficulty falling asleep
- ☐ Wake ___x/ night @_____am / pm
- ☐ Wake to urinate *How often?*_____
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested upon waking

Head, Eyes, Ears, Nose, Throat

- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excess earwax

- ☐ Sore throat
- ☐ Frequent Coughs
- ☐ Swollen Glands
- ☐ Hoarseness
- ☐ Trouble Swallowing
- ☐ Poor vision
- ☐ Night Blindness

- ☐ Headache
- ☐ Migraine
- ☐ Head Injury
- ☐ Dizziness
- ☐ Vertigo
- ☐ Hay Fever

- ☐ Sinus congestion
- ☐ Nose Bleeds
- ☐ Loss of Smell
- ☐ Phlegm (*color*_____)

- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Teary Eyes
- ☐ Dry Eyes
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Spots in front of eyes

- ☐ Dental problems
- ☐ Mouth sores
- ☐ Jaw Problems /TMJ
- ☐ Teeth Grinding

FABRIQ
A SEAMLESS SPA

Facial Acupuncture

3 Main concerns:

1._____ 2. _____ 3._____

Current Beauty Routine: *Please include brand name*

Cleanser _____ Toner _____ Moisturizer _____ Masks _____
Do you use sunscreen? ☐ Yes ☐ No

Have you had facelift surgery? ☐ Yes ☐ No ☐ Full ☐ Partial
If so: When _____ Where _____Satisfied? ☐ Yes ☐ No
Please Elaborate _____

Facial Treatments: Type _____How often?_____

- ☐ Microdermabrasion
- ☐ Chemical Peels
- ☐ Photolight rejuvenation
- ☐ Filler
- ☐ Retin-A
- ☐ Botox
- ☐ Collagen Injections
- ☐ Renova

Skin

- ☐ Wrinkles
- ☐ Blemishes
- ☐ Acne
- ☐ Dryness
- ☐ Oily
- ☐ Eczema
- ☐ Herpes
- ☐ Rashes
- ☐ Sagging
- ☐ Dullness
- ☐ Eczema
- ☐ Psoriasis

Discolorations: ☐ Age Spots ☐ Sallow (yellow) complexion ☐ Rosacea (Redness)

Eyes

- ☐ Dark eye circles
- ☐ Wrinkles
- ☐ Dry skin around eyes
- ☐ Styes
- ☐ Puffy and swollen
- ☐ Eye bags
- ☐ Puffy upper lids

Neck

- ☐ Crepey Skin
- ☐ Wrinkles
- ☐ Sagging jowls
- ☐ Turkey Wattle

Lips

- ☐ Fine lines
- ☐ Cracking
- ☐ Cold Sores
- ☐ Herpes

Hair

☐ Thin Hair
☐ Alopecia (baldness)

Hair follicle treatments?
☐ Yes ☐ No

If so, When?_____

☐ Excess Facial Hair
Electrolysis treatments: ☐ Yes ☐ No

If so, When? _____

Thank You For Taking The Time To Complete Prior To Your First Treatment

FABRIQ
A SEAMLESS SPA

Fabriq Spa Protects 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[1].

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 (215) 955-3235.

Yours truly,

Gabrielle Applebaum, Acupuncturist
Board Certified, (NCCAOM)
L.Ac, M.Ac, Dipl.Ac, MTS

[1] HIPPA

Acknowledgement of Privacy
For Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Fabric Spa, LLC and its employees (the "Recipients") 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. The Recipients are not required to agree to the restrictions that I may request. However, if the Recipients agree to a restriction that I request, the restriction is binding upon them.

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 the Recipients' 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 the Recipients. This Notice of Privacy Practices also describes my rights and the duties of my practitioners with respect to my identifiable health information.

The Recipients reserve 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 accessing the website or requesting the most current notice during any office visit.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name and Relationship

Informed Consent for Acupuncture Facial

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. Please initial each page, indicating that you have read the page, and sign the consent for facial acupuncture treatments, as proposed by your acupuncturist.

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 will disappear, and deeper ones be reduced. As 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 (hematomas), 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.

UNSATISFACTORY RESULT: There is the possibility of a poor result from an acupuncture facial. You may be disappointed with the results.

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.

HEALTH INSURANCE: Most health insurance companies exclude coverage for an acupuncture facial and/or any complications that might occur from an acupuncture facial. Please carefully review your health insurance subscriber information pamphlet.

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. 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 the results that may be obtained.

FINANCIAL RESPONSIBILITIES: The cost of an acupuncture facial involves several charges for the services provided. The total includes fees charged by your acupuncturist, the cost of acupuncture supplies and topical preparations. Depending on whether the cost of your acupuncture facial is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles and charges not covered.

DISCLAIMER: Informed-consent documents are used to communicate information about the proposed procedure along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your acupuncturist may provide you with additional or different information which is based upon all the facts in your particular case and the present state of knowledge within the field of acupuncture. Informed consent documents are not intended to define or serve as the standard of acupuncture. Standards of acupuncture are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

It is important that you read the above information carefully and have all of your questions answered before signing the consent below.

Consent for Facial Acupuncture Procedure or Treatment

1. I hereby authorize Fabric Spa, LLC to perform the following: an acupuncture facial. I have received the following acupuncture facial sheet: Informed Consent for Acupuncture Facial.
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 guarantee has been given by anyone as to the results that may be obtained.
4. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical device registration, if applicable.
5. It has been explained to me in a way that I understand:
   a. The above treatment or exposure to be undertaken.
   b. There may be alternative procedures or methods of treatment.
   c. There are risks to the procedure or treatment Proposed.

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE-LISTED ITEMS (1-5). I AM SATISFIED WITH THE EXPLANATION.

Patient or Person Authorized to Sign for Patient _____

Practitioner _____

Date _____