
Arden Yingling, L.Ac., MAcOM (TX #AC01588)
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**New Facial Rejuvenation Patient Information**

Name _____ Today's Date _____

Street Address _____ Apt. _____

City _____ State _____ Zip _____

Preferred Phone _____ Email _____

Birth Date _____/_____/_____ Age _____

Occupation/Employer _____

Relationship Status_____

Number of Children_____ Names/Ages of Children _____

Name of Primary Care Physician: _____

Name of OB-GYN/Midwife (if applicable): _____

Referred by _____

Emergency Contact: Name _____ Phone _____

**YES / NO** I give Arden Yingling, L.Ac., permission to email me appointment notifications and occasional announcements.

**Cancellation Policy: If you need to change or cancel your appointment, please do so with a minimum of 24 hours notice. Failure to do so will result in being charged a $40 fee.**

**YES / NO** I understand the cancellation policy.

**Signature:**_____ **Date:** _____/_____/_____

*(continued onto next pages)*

# FACIAL REJUVENATION: ASSESSMENT

## CONTRAINDICATIONS FOR FACIAL REJUVENATION ACUPUNCTURE

*Please circle all conditions that you currently have or have had in the past (to the best of your knowledge):*

Uncontrolled high blood pressure

Chronic headaches or migraines

Chronic dizziness, vertigo, or fainting

Hemophilia or other bleeding/clotting disorder

Compromised immune system

History of seizures or epilepsy

Other severe, life-threatening condition

## CAUTIONS FOR FACIAL REJUVENATION ACUPUNCTURE

*Please circle all conditions that you currently have or have had in the past (to the best of your knowledge):*

Pregnancy/trying to conceive

Recent injectables or Botox

Taking fish oil

Taking prescription blood thinners

**Conditions:**

By signing this agreement, I am acknowledging that I have read the above contraindications for cosmetic acupuncture. I also affirm that I do not have the above list of conditions to the best of my knowledge and will inform Songbird Acupuncture if I acquire any of the aforementioned conditions during the course of our treatment.

Patient (or Representative) Signature: _____ Date: _____

**SKINCARE HISTORY**
*Please circle up to three of the following conditions that are of the MOST concern to you.*

Wrinkles, please specify:

- Crow's feet (eyes)
- Around lips
- Nasolabial groove (nose to mouth)
- Other: _____

Sagging face/jowls

Bags/swelling under eyes

Droopy eyelids

Double chin

Large pores

Oily skin

Dry skin

Lusterless skin

Acne

Acne scarring

Rosacea

Sun damage (dark spots)

Other: _____

**SKIN PROCEDURES**
*Please circle all procedures you've had or are currently undergoing.*

Botox Injections Date(s): _____

Laser procedures Date(s): _____

Collagen Injections Date(s): _____

Threading (Lift) Date(s): _____

Restylane Date(s): _____

Rhytidectomy (Face Lift) Date(s): _____

Silicone injections Date(s): _____

Blespharoplasty Date(s): _____

Mesotherapy Date(s): _____

Brow or Coronal Lift Date(s): _____

Microdermabrasion Date(s): _____

Other: Date(s): _____

Chemical Peels Date(s): _____

**GENERAL HEALTH HISTORY**

Have you had acupuncture before, and for what reason?

_____

If yes, was acupuncture beneficial? _____

What is the main issue you are seeking treatment for today? _____

_____

What diagnosis have you received for this problem, if any?_____

When did this problem begin? _____

Do you know what caused it? _____

_____

How does this issue affect your daily life?

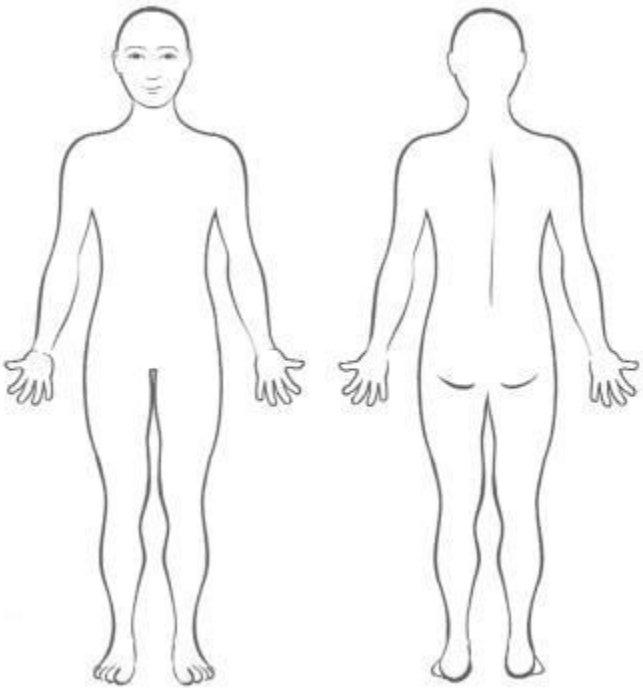
_____

Are there any other health issues you would like to work on? _____

_____

_____

**Please mark any areas of pain or discomfort, if that is the reason for your visit today:**



**Please CIRCLE any symptoms you are CURRENTLY experiencing or have experienced in the RECENT past:**

**GENERAL**

| | | |
|---|---|---|
| Sweating easily during the day | Fevers | Unexpected weight loss/gain |
| Night sweating | Chills | Run hot |
| Fatigue | Change in appetite | Run cold |

Sudden energy drop (What time of day? _____

Favorite time of year? _____ Worst time of year? _____

**SKIN/NAILS**

| | | |
|---|---|---|
| Rashes/hives | Dry skin | Bruise easily |
| Psoriasis | Acne | Slow wound healing |
| Eczema | Itching | Weak/brittle nails |

**MUSCULOSKELETAL**

| | | |
|---|---|---|
| Neck pain/tightness | Knee pain | Hand/foot pain |
| Shoulder pain | Hip pain | General muscle soreness |
| Back pain | Leg/arm pain | Spinal curvature |

**HEAD/EARS/EYES/NOSE/THROAT**

| | | |
|---|---|---|
| Headaches/migraines | Hearing loss | Itchy eyes |
| Dizziness/vertigo | Sinus pressure | Dry eyes |
| Earaches/pressure in the ears | Blurry vision | Teeth/jaw clenching |
| Ringing in the ears | Eye floaters (spots) | Difficulty swallowing |

**CARDIOVASCULAR/CIRCULATORY**

| | | |
|---|---|---|
| Chest pain | Fainting | Cold hands & feet |
| Palpitations/Irregular heartbeat | High blood pressure | Blood clots |
| Swelling/edema | Low blood pressure | |

**RESPIRATORY**

| | | |
|---|---|---|
| Frequent colds/flu | Chest tightness | Excess phlegm production |
| Seasonal/other allergies | Nasal congestion | Asthma or wheezing |
| Pain on inhaling | Cough | |

**DIGESTIVE**

| | | |
|---|---|---|
| Heartburn/reflux | Constipation | Ulcer |
| Gallbladder problems | Diarrhea | Mucus or blood in stool |
| Belching | Nausea/vomiting | Sores on lips/tongue |
| Gas/bloating | Abdominal pain/cramps | Hemorrhoids |

**URINARY/GENITAL**

| | | |
|---|---|---|
| Difficulty urinating | Urgent/freq. urination | Frequent UTIs |
| Pain upon urination | Blood in urine | Genital pain |

**EMOTIONAL/PSYCHOLOGICAL**

| | | |
|---|---|---|
| Anxiety | Suicidal thoughts | Trouble falling asleep |
| Depression | Frequent crying | Trouble staying asleep |
| Irritability/anger | Susceptible to stress | Vivid/disturbing dreams |
| Worry a lot | Difficulty concentrating or poor memory | History of abuse/trauma |

**NEUROLOGICAL**

| | | |
|---|---|---|
| Loss of balance/coordination | History of concussion | Areas of numbness/paralysis |

**FOR WOMEN ONLY:**

| | | |
|---|---|---|
| Unusual vaginal discharge | Endometriosis | Night sweating |
| Ovarian cysts | Fertility issues | |
| Fibroid cysts | Hot flashes | |

Age at first menses _____ # of days in a typical cycle _____ # of days of bleeding _____

# of pregnancies _____ # of births _____

# of miscarriages _____ # of abortions _____

Have you been through menopause? Age? _____

Do you practice birth control? If yes, what type and for how long? _____

Do you regularly experience PMS? If yes, please circle any symptoms you experience regularly:

| | | |
|---|---|---|
| Acne | Cramping | Headache or migraine |
| Bloating | Diarrhea | Irritability |
| Breast tenderness | Fatigue | |
| Constipation | Food cravings | |

Do you have any clotting with your period? YES / NO

Do you have spotting before or between periods? YES / NO

Is your menstrual flow usually LIGHT / MEDIUM / HEAVY (circle one)

Are you now or are you currently trying to become pregnant? _____

If you are pregnant, when is your estimated due date? _____

Are you currently breastfeeding? _____

---

**LIFESTYLE**

Current medications/herbs/supplements:

_____

_____

Do you follow any certain way of eating? (Vegetarian, vegan, gluten-free, dairy-free, paleo, etc.)

_____

_____

How much water do you drink per day? _____

Do you exercise? What and how often?_____

_____

Do you drink coffee or caffeinated tea? If yes, how much? _____

Do you eat sugar regularly? _____

Do you use tobacco? If so, how often?_____

Do you drink alcohol? If so, how many drinks/week? _____

Do you spend time outside? _____

Do you have supportive relationships in your life? _____

Do you enjoy your job (if employed outside the home)? _____

What do feel needs to happen for you to get better?

_____

_____

How much change are you willing to make at this time for improving your health? (circle one)

MINIMAL SOME AS MUCH AS RECOMMENDED

**OTHER MEDICAL HISTORY**

Are you currently taking any of the following medications? *(circle if yes)*

| | | |
|---|---|---|
| Advil/Motrin/Ibuprofen | Bayer/Aspirin | Prednisone/Prednisolone |
| Aleve/Naproxen | Prilosec or other acid reducer | Coumadin/Warfarin |

Allergies (medications/foods/chemicals/etc.):

_____

_____

Have you ever had a seizure? If yes, indicate date of most recent: _____

**Please circle any significant illnesses and indicate date:**

| | | |
|---|---|---|
| Anemia | Epilepsy | Stroke |
| Arthritis | Heart disease | Substance abuse |
| Cancer | Hepatitis | Thyroid disease (hypo or hyper) |
| COPD/breathing problems | HIV | Tuberculosis |
| Diabetes | High blood pressure | Other _____ |

Please list any major surgeries/hospitalizations or significant trauma and approximate dates:

_____

_____

**FAMILY MEDICAL HISTORY (circle if your parents, siblings, or other immediate family have experienced)**

| | | |
|---|---|---|
| Asthma | Hepatitis | Substance abuse |
| Cancer | High blood pressure | Emotional disorders |
| Diabetes | Seizures | Other _____ |
| Heart attack | Stroke | |

**Please list any other relevant information or issues you would like to discuss:**

Songbird
Acupuncture

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# Informed Consent for Facial Rejuvenation Acupuncture

## 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 sings of aging. 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 substitution 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, bring more firmness to sagging skin, enhance the radiance of the complexion, and flesh out sunken areas. Typically, fine wrinkles will be greatly reduced, and deeper wrinkles will become more shallow. This treatment is not merely confined to the face, but incorporates the entire body and constitutional issues of health, and may result in other whole body benefits over time.

## RISKS OF FACIAL REJUVENATION ACUPUNCTURE

Every procedure involves a certain amount of risk and it is important that you understand the risks involved with facial rejuvenation acupuncture. An individual's choice to undergo facial rejuvenation acupuncture 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 facial rejuvenation acupuncture.

### Bleeding

It is possible that you will experience bleeding during facial acupuncture. Should post-acupuncture bleeding occur, it will usually only consist of a few drops. In rare instances, accumulations of blood under the skin may cause a bruise (hematoma), which will resolve itself.

### Infection

Infection is extremely unusual after facial acupuncture. Should an infection occur, additional treatment may be necessary.

### Damage to Deeper Structures

Deeper structures such as blood vessels and muscles are rarely damaged during the course of facial rejuvenation 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 (hematoma), puffiness, blood, tingling, itching, warmth, pain or other symptoms at the site of the needle.

**Nerve Injury**
Injuries to 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 a facial acupuncture treatment and typically resolves quickly.

**Unsatisfactory Result**
There is the possibility of a poor result from facial rejuvenation acupuncture. You may be disappointed with the results.

**Allergic Reactions**
In rare cases, local allergies to topical preparations have been reported. Allergic reactions may require additional treatment.

**Delayed Healing**
Delayed wound healing or wound disruption is a rare complication experienced by patients in the aftermath of facial acupuncture. 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 facial rejuvenation acupuncture. Facial acupuncture 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 facial rejuvenation acupuncture.

**Additional Care Necessary**
There are many variable conditions in addition to risk and potential complications that may influence the long term result from facial acupuncture treatments. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with facial rejuvenation acupuncture 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 facial rejuvenation acupuncture involves several charges for the services provided. The total includes fees charged by your acupuncturist, the cost of any supplies you may choose to purchase, and topical preparations you may choose to purchase. All payment is due at the time services are rendered.

**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 following consent.

**CONSENT FOR FACIAL REJUVENATION ACUPUNCTURE TREATMENT**

I.

I hereby authorize Arden Yingling, L.Ac., of Songbird Acupuncture to perform facial rejuvenation acupuncture. I have received the INFORMED CONSENT FOR FACIAL REJUVENATION ACUPUNCTURE.

II.

I recognize that during the course of the facial rejuvenation acupuncture treatment, unforeseen conditions may necessitate different procedures than those above. I therefore authorize Songbird Acupuncture 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.

III.

I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

IV.

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. I am satisfied with the explanation.

_____ _____ _____

Patient's Name (Printed) Patient's Signature Date

**PHOTOGRAPHIC CONSENT**

The purpose of before and after photos is to document the progress of treatment. Such documentation will help you see changes that could be overlooked. Please read and initial each statement to which you consent and please mark N/A next to the statements to which you do not consent.

_____ I consent to have my pictures taken for comparison purpose, but do not consent to have them used for teaching, advertising, or publication of any time.

_____ I consent to have my pictures used in your advertising materials. I understand that my name will not be disclosed without written permission.

_____ I consent to have my pictures used on your website. I understand that my name will not be disclosed without written permission.

_____ _____ _____

Patient's Name (Printed) Patient's Signature Date


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## Texas Acupuncture Requirements

In the state of Texas, acupuncture and Chinese medicine is not considered "primary health care." Licensed acupuncturists are permitted to treat the following conditions without any extra evaluation or referrals. If you are here today for any of these, please check the appropriate line below and **skip the remainder of this page.**

___Chronic Pain (over 3 months) ___Smoking addiction ___Weight loss ___Alcoholism ___Substance abuse

***For all other conditions, please fill out the state required form below.***

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**Form to be Completed by Patient, Notifying the Acupuncturist of Whether He/She Has Been Evaluated by a Physician, and Other Information.**

(Pursuant to the requirements of 22 TAC §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) _____, am notifying Songbird Acupuncture of the following:

___ Yes ___ No I have been evaluated by a physician or dentist within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

_____ (initials of patient) Date: _____

***or***

___ Yes ___ No I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

_____ _____

Patient Signature Required Date

*Songbird Acupuncture is not responsible for untrue statements made by patients.*

Songbird Acupuncture

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## HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the Songbird Acupuncture "Notice of Privacy Practices." I understand that I have the right to review "Notice of Privacy Practices" prior to signing this document.

I understand that Songbird staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my voicemail or with anyone who answers the phone.

I also understand that my clinical information may be used for educational and/or research purposes by Songbird Acupuncture. All information that can identify me personally will be removed.

By signing this form, I am giving Songbird Acupuncture authorization to contact me and am giving my informed consent to utilize my information for research and educational purposes. I acknowledge that all information discussed during the assessment and treatment at Songbird Acupuncture will be held confidential except in the instance where my safety or the safety of others may be at risk.

_____ _____

Patient Name (print) Date

_____

Patient Signature

---

## Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Songbird Acupuncture the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____ _____

_____ _____

_____

_____ _____