CastelliniCare
206 Broad Street, Red Bank, NJ 07701 732–219-1900

Facial Rejuvenation Acupuncture Registration

This questionnaire provides valuable information to help us understand the underlying causes of your health concerns. All information contained in this form is strictly confidential and will become part of your medical record on file.

Patient Name _____ Date _____

Skin Care History

Please check any of the following which are of most concern to you:

□ Bags/Swelling under eyes	□ Sagging Face	□ Vertical Creases/furrows
□ Wrinkle	□ Droopy eyelids	□ Premature graying of hair
□ Nasolabial (nose to mouth)	□ Double chin	□ Sun damage
□ Eyes (crow's feet)	□ Acne/Acne Scarring	□ Lips
□ Rosacea	□ Large pores	□ Oily skin
□ Dry skin	□Broken capillaries	□ Protruding temporal veins
□ Lusterless skin		

□ Other skin conditions / issues _____

Do you wear make up daily □ Yes □ No Do you wear sunscreen daily □ Yes □ No

Please describe your current skin care regimen and products that you use (Toner, astringent, exfoliation, masks, etc.)

_____

_____

Please describe any skin sensitivities or allergies

_____

What improvements would you like to see?

_____

Do you go to tanning booths □ Yes □ No

Do you participate in vigorous aerobic activity or sport □ Yes □ No

Do you get facial waxing/electrolysis or use depilatories □ Yes □ No (If yes, wait 5 days between treatments)

Please check all procedures you have 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	Date(s) _____
□ Silicon injections	Date(s) _____	□ Blepharoplasty	Date(s)_____
□Mesotherapy	Date(s)_____	□ Brow or Coronal lift	Date(s)_____
□Microdermabrasion	Date(s)_____	□ Chemical Peels	Date(s)_____
□ Other	Date(s)_____		