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

Facial Rejuvenation Acupuncture - Initial Visit

Name Last _____ First _____

Date of Birth _____/_____/_____ Gender F_____ M _____

Email _____

Address: _____ City _____

State _____ Zip Code _____

Telephone Cell (____)_____-_____ Work (____)_____-_____

Occupation _____

Height _____Weight _____ Blood Pressure _____ Pulse _____

Have you ever had an acupuncture facial ? Y ____ N ____

Have you been treated by Acupucture or Oriental medicine before Y _____ N _____

Name of your physician _____Phone number _____

In an Emergency Notify: Name _____ Relationship to patient _____

Home (____)_____-_____ Cell (____)_____-_____ Work (____)_____-_____

FINANCIAL AGREEMENT

Payment for Clinic Services Rendered: Credit card is required to make an appointment and will be charged at time of service.
Cancellation Policy: Please be respectful of the time set aside for your treatment. All scheduled appointments require a 24-hour cancellation notice or the patient will be charged for a **FULL** office visit fee.
By signing this agreement, I am acknowledging that I have read the above financial policies and will be responsible for all charges stated above.

Patient's Signature _____Date_____

MEDICAL HISTORY

Past and Present Illnesses (with dates)

_____

Surgeries (with dates)

_____

Significant Trauma (Auto accidents, falls, etc., with dates)

_____

Do you have, or have you ever had, any **Infectious Diseases?** Yes _____No ____ If so, please describe:

_____

Current Medications (prescription and over the counter drugs, vitamins, herbs, etc)

_____

Allergies:

_____

Do you bruise or bleed easily? Yes _____ No _____

PERSONAL HISTORY

Hobbies & Recreational Habits _____

Do you have a regular exercise program? Yes _____ No _____ If so, please describe

_____

Smoking? Yes _____ No _____ Alcohol? Yes _____ No _____

PLEASE CHECK IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING IN THE LAST SIX MONTHS

□ Fever □ Chills □ Poor Appetite □ Night Sweats □ Bleeding or Bruising □ Fatigue

□ Sudden energy drops What time of day? _____

□ Poor Sleep /Insomnia □ Dream Disturbed Sleep □ Emotional Changes

□ Weight loss □ Weight Gain □ Strong thrist for Hot or Cold drinks?

□ Joint Pain □ Localized Weakness □ Poor Balance

NEUROPSYCHOLOGICAL

□ Seizures □ Areas of Numbness □ Anxiety □ Concussion □ Lack of Coordination □ Poor Memory

□ Dizziness □ Loss of Balance □ Easily Angered □ Headaches □ Fainting □ Depression/Biopolar

□ Migraines □ Disorientation □ Easily Susceptible to Stress

GYNECOLOGY

□ Birth Control □ Painful Periods □ Irregular Periods □ Heavy Periods □ Light Periods □ PMS □ Pregnant

□ First date of last menstrual cycle _____

CARDIOVASCULAR

□ High Blood Pressure □ Dizziness □ Swelling of Hands □ Blood clots □ Irregular heartbeat □ Fainting

□ Difficulty in Breathing □ Palpitations □ Low Blood Pressure □ Cold Sweats □ Cold Hands / Feet

□ Chest pain □ Swelling of Feet

RESPIRATORY

□ Cough □ Pain w / Deep Breaths □ Asthma □ Bronchitis □ Shortness of Breath

GASTROINTESTINAL

□ Nausea □ Abdominal Pain/ Cramps □ Dgestive Disorders □ Vomiting □ Constipation □ Indigestion

URINARY

□ Pain on Urination □ Frequent Urination □ Waking up to Urinate □ Unable to Hold Urine