

**Microcurrent Facial Rejuvenation**  
**1920 NW Lovejoy Street**  
**Portland OR 97209**  
**503-417-1774**

**Name** ..... **Referred By** .....

**Today's Date** ..... **Date of Birth** .....

**Address** ..... **City/State/Zip** .....

**Telephone (H)** ..... **(W)** .....

**Occupation** .....

1a) Have you ever received a facial acupuncture treatment? .....

b) Have you ever received a facial non needle acupuncture treatment? .....

c) Have you ever had facial cosmetic surgery? .....

2) What are your major facial concerns? .....

.....

3) What are you hoping to accomplish with Facial Rejuvenation? .....

.....

4) How much sun exposure do you get? (average number of hours per week).....

.....

5) Has your face received excessive sun or UV light exposure in the last 24hrs? .....

6) How many glasses of water do you drink per day? .....

7) How many alcoholic beverages do you drink per week? .....

8) If you smoke, how many cigarettes do you smoke per week? .....

9) Are you currently pregnant?.....

