Amethyst
Holistic Skin Solutions

New Patient Form

Date: ____________________________________

Name: ___________________________________ Birthdate: __________________Age: _______

Sex: Female______ Male _____ Transgender ______ Height: _____Weight:______

Email address: ____

Address: __________________________________ Occupation: ___________________________

City: _________________________ State: _______ Zip: ___________

Cell Phone: ________________________________ Evening Phone: ________________________

Relationship Status:

- Single
- Married/Partnered
- Separated
- Divorced
- Widowed

Spouse/Partner Name: ________________________ Spouse/Partner Phone: __________________

Emergency Contact: _________________________ Emergency Contact Phone: _______________

Family Physician: ____________________________ Last seen: (date) ________________________

Referred to Amethyst by: _____________________________

What is/are the main problem(s) you are seeking facial acupuncture or TCM skincare to help with?
____

Were you previously diagnosed for these issues? ______If so, what was the diagnosis and by whom?
____

What products have you used to treat these issues?
____

Have you ever had a facial acupuncture? ______ Do you Bruise easily? ____________________

Do any of the below conditions apply to you today? (Check all that apply):

- Severe high blood pressure
- Migraines (more than 1X every 3 mos.)
- Pregnant
- Cold/Flu
- Acute Allergic Reaction
- Microdermabrasion or chemical peels within last 2 weeks
- Laser resurfacing within last 3 months
- Face-lift surgery within last 6 months

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What medications are you taking?
____
For what conditions?
____

What supplements are you taking?
____

Medical History (check all that apply)

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies:
  To what? ____________________________
- ☐ Allergies to Cosmetics (name):
- ☐ Asthma
- ☐ Birth Trauma
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Heart Disease
- ☐ Hepatitis A/B/C
- ☐ Herpes
- ☐ Lyme Disease
- ☐ Mitral Valve
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Tuberculosis
- ☐ Latex Allergy
- ☐ Lymph nodes removed
- ☐ Varicose Veins
- ☐ Other ______________________

Injuries, Surgeries,

Please provide details:
____

Dates:
____

Diet

Describe your daily diet:

Breakfast	Lunch	Dinner	Snacks

Food Cravings? ____

Food Intolerances? ____

How many glasses/cups do you drink each day?

Water______ Soda______ Coffee______ Tea ______ Alcohol______ Are you Vegan _______ Vegetarian_______ For how long? _________ How many servings per day do you consume?

Meat ______ Sugar/Sweets ______ Dairy/Milk/Cheese/Yogurt ______

Do you perspire during the day? ______

Do you perspire at night? ______

Are you always thirsty? _______

Do you prefer HOT or COLD drinks? (Circle one)

Taste preferences (Indicate 1-5; 1=Most liked, 5=Disliked)

Salty ______ Sour ______ Bitter ______ Sweet ______ Spicy ______

Gastrointestinal

Do you have or have you had? (Check all that apply)

- ☐ Belching
- ☐ Nausea
- ☐ Vomiting
- ☐ Ulcers
- ☐ Bloating
- ☐ Indigestion
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Acid Reflux

Exercise and Energy

What kind of exercise do you engage in?________________________________
How often? ______
How is your general energy level? ______________________

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Emotions & Sleep

- ☐ Panic Attacks
- ☐ Depression
- ☐ Anxiety
- ☐ Nerves
- ☐ Fear
- ☐ Poor Memory
- ☐ Difficulty concentrating
- ☐ Difficulty falling asleep

- ☐ Restless sleep
- ☐ Dream Disturbed sleep
- ☐ Take anti-depressants

What kind? ______________________________

- ☐ Take sleeping bills

What Kind? _____________________________

Wake-up time _______ Sleep Time_________

Please rate the following regarding your relationships and lifestyle:

	Great	Good	Fair	Poor	Bad	Comments
Spouse						
Family						
Living Situation						
Diet						
Sex Life						
Self						
Work						
Exercise						
Spirituality						
Other						

Urination

How often? ________times per day

Color ______________________________

Check all that apply:

- ☐ Frequent
- ☐ Incontinence
- ☐ Burning
- ☐ Bladder Infections

Bowel Movement

How often? ________times per day

Color ______________________________

☐ Easy ☐ Formed ☐ Difficult ☐ Loose

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Gynecology

Are you still menstruating? ________ Check all that apply:

Irregular Menses

- ☐ Heavy Flow
- ☐ Light Flow
- ☐ No Flow
- ☐ Blood Clots
- ☐ PMS
- ☐ Painful Periods
- ☐ Uterine fibroids
- ☐ Cystic Breasts

Are you premenopausal? ______ Symptoms ____

Are you menopausal? ______ Symptoms ____

Respiratory, ENT, Head

Do you smoke? __________times/day for _______years Check all that apply:

- ☐ Frequent Colds
- ☐ Asthma
- ☐ Dizziness
- ☐ Cold Sores
- ☐ Bleeding Gums
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Ringing in ears
- ☐ Clogged Ears
- ☐ Popping Ears
- ☐ Frequent Headaches
- ☐ Migraine

Cardiovascular

Do you have or have you had? (Check all that apply)

- ☐ Palpitations
- ☐ Varicose Veins
- ☐ Spider Veins
- ☐ Cold hands/feet
- ☐ Mitral valve
- ☐ Poor circulation
- ☐ Irregular Heart beat

Skin/Hair

Do you have or have you had? (Check all that apply)

- ☐ Dry skin
- ☐ Skin rashes
- ☐ Itching
- ☐ Acne
- ☐ Eczema
- ☐ Hives
- ☐ Hair loss

Are there any additional health conditions that I should be informed of? (Please explain below)

____

____

____

____

To be completed by practitioner

BP: ____________________ Body Temp: _____________

Tongue: ____

Pulse: ____

Element: ____