**Pathways To Health Wellness Center**
517 S. Orange St., Media PA 19063

# AcuGlow™ Treatment Intake

*This questionnaire provides valuable information which helps us understand the underlying causes of your health concerns. All questions contained in this history form are strictly confidential and will become part of your medical record on file.*

**PATIENT NAME:** _____ **DATE:** _____

## SKIN CARE HISTORY

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

☐ Bags / swelling under eyes
☐ Sagging face
☐ Wrinkles
  ☐ Nasolabial (nose to mouth)
  ☐ Eyes (crow's-feet)
  ☐ Lips
  ☐ Other: _____
☐ Vertical creases / furrows
☐ Premature graying of hair
☐ Droopy eyelids
☐ Double chin
☐ Oily skin
☐ Dry skin
☐ Lusterless skin
☐ Acne
☐ Acne scarring
☐ Rosacea
☐ Sun damage
☐ Large pores
☐ Broken capillaries
☐ Protruding temporal veins
☐ Other skin conditions/issues: _____

2. What improvements to your skin would you like to see?

_____
_____
_____

3. Please describe any skin sensitivities or allergies:

_____
_____
_____

4. Do you wear sunscreen daily? ☐ Yes ☐ No

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

_____
_____

6. Do you go to tanning booths? ☐ Yes ☐ No

7. Do you get facial waxing / electrolysis / or use depilatories? ☐ Yes (wait approximately 5 days before treatment) ☐ No

8. Please check all procedures you have had or are currently undergoing.

☐ Botox injections Date(s): _____
☐ Collagen injections Date(s): _____
☐ Restylane Date(s): _____
☐ Silicone injections Date(s): _____
☐ Mesotherapy Date(s): _____
☐ Microdermabrasion Date(s): _____
☐ Chemical peels Date(s): _____
☐ Microblading Date(s): _____
☐ Laser procedures Date(s): _____
☐ Threading (Lift) Date(s): _____
☐ Rhytidectomy Date(s): _____
☐ Blepharoplasty Date(s): _____
☐ Brow or Coronal lift Date(s): _____
☐ Other: _____ Date(s): _____

9. Date of your last menstrual period: _____

# Informed Consent for AcuGlow™ Treatment

**Introduction**

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The **AcuGlow™** treatment uses Gua Sha, cupping, and LED light on the face and neck to reduce the visible signs of aging. No needles are used on the face. Acupuncture body points are chosen based on one's individual needs and goals of the treatment to promote healing on a deeper level.

**Risks of the AcuGlow™** treatment
Every procedure involves a certain amount of risk and it is important that you understand the risks involved with the **AcuGlow™** treatment. 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 the **AcuGlow™** treatment

- *Bruising*: There is a possibility of bruising (hematoma) from needles, petechiae (red/purple marks) from the gua sha tool, and red/purple marks from cupping.
- *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 products have been reported. Allergic reactions may require additional treatment.

**Long Term Effects**
The **AcuGlow™** treatment does not stop the aging process or permanently alter the appearance of the face and neck. Future treatments may be necessary to maintain the results of the **AcuGlow™** treatment.

**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 AcuGlow™ TREATMENT**

1. I hereby authorize licensed acupuncturists and such assistants of The Still Point as may be selected to perform facial rejuvenation acupuncture. I have received the INFORMED CONSENT FOR ACUGLOW™ TREATMENT.

2. I recognize that during the course of the **AcuGlow™ Treatment**, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the acupuncturists and assistants or designees of Pathways To Health Wellness Center 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.

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

4. 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 (1-4). I AM SATISFIED WITH THE EXPLANATION.**

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