# Cosmetic Acupuncture Questionnaire

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your main skin complaint.

What improvements would you like to see?

Please describe any skin sensitivities or allergies.

Please describe your current **skin care regimen** and ***products*** that you use. (toner, astringent, exfoliation, masks, ect.)

Do you wear makeup daily? Yes / No Do you wear sunscreen daily? Yes / No

What procedures have you had? or are currently undergoing? (e.g. botox, collagen, laser, cold sculpting, cold laser, micro-dermabrasion, surgery, post-partum, etc.) **Please include dates.**

Please describe any other skin conditions/issues you have.