Healing Axis
Integrative Energy Medicine

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Energy Light Rejuvenation Questionnaire

General Contact Information

Name: _____Age: _____

Date of Birth:_____ Gender: (please circle) Male / Female

Address:_____

Telephone: Home: _____Work:_____ Cell:_____

(Contact Preference: [please circle] Home / Work / Cell)

E-mail:_____ Occupation:_____

Emergency Contact: Name: _____ Relationship:_____

Telephone:_____

Primary Physician: Name:_____Telephone:_____

Facial Concerns

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

□ Bags / swelling under eyes	□ Eyes (crowsfeet)	□ Lusterless skin
□ Sagging face	□ Rosacea	□ Age spots
□ Jowls	□ Lips	□ Sun damage
□ Wrinkles	□ Large pores	□ Double chin
□ Vertical creases / furrows	□ Droopy eyelids	□ Broken capillaries
□ Nasolabial (nose to mouth)	□ Premature graying of hair	□ Acne scarring
□ Acne	□ Dry skin	□ Protruding temporal veins

□ Other _____

Please describe your main skin complaint if it's not listed above.

What improvements would you like to see? _____

_____

_____

Please describe any skin sensitivities or allergies.

_____

_____

_____

(over)

Please describe any other skin conditions/issues you have.

_____

_____

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

_____

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

What procedures have you had or are currently undergoing?

_____

_____

Botox injections Date(s):_____

Collagen injections Date(s): _____

Restalyne Date(s): _____

Silicon injections Date(s): _____

Mesotherapy Date(s): _____

Microdermabrasion: Date(s): _____

Chemical peels 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):

_____

_____

_____