



Microcurrent Treatment Intake

Name: _____ Date: _____

Address: _____

Home phone number: _____ Cell number: _____

Email address: _____

Occupation: _____ Age: _____ DOB: _____

How did you hear about the clinic? _____

Personal Medical History:

Are you presently in a physician's care? _____ If yes, why? _____

Any major surgeries, illnesses or accidents? If so, please list with dates.

Any contagious diseases? If so, please list. (ie. HIV, Hepatitis, herpes, etc)

Any known allergies? If so, please list.

Are you currently taking any medications? If so, please list.

Are you currently taking any supplements or vitamins? If so, please list.

Do you smoke? _____ If so, how much per day? _____

Do you consume alcohol? _____ If so, how often? _____

Do you exercise regularly? _____ What types of exercise do you prefer? _____

Do you have an outlet for stress? _____

Are you staying hydrated daily? _____ How much water do you drink? _____

What is your diet like? _____

Are you in the sun often? _____ Do you wear protective gear or sunscreen? _____

Are you getting enough sleep every day? _____

Please check any health conditions which you have had or are now experiencing:

Allergies	Heart Disease / Problem	Pain (describe below)
Auto Immune	Hepatitis	
Bruise easily	Immune Disorders	
Cancer	Infection of any type	Phlebitis/Vein Inflammation
Candida	Insulin Pump	Pregnancy
Chemical Sensitivities	Lack of Skin Sensation	Recent Illness
Cold Sores	Low/High Blood Pressure	Respiratory Issues
Decreased skin sensation	Metal Implants	Skeletal Problems
Diabetes	Migraines	Skin Problems
Digestion Issues	Muscular Conditions	Seizures
Dizziness	Muscular Sclerosis	Thrombosis
Epilepsy	Pacemaker	Tumors
Other (describe below)		

Cosmetic History Questions:

Do you have any sensitivities to specific products? _____ If yes, please list: _____

Have you had cosmetic surgery? _____ If so, please list procedures: _____

Do you get in office cosmetic procedures? _____ How often? _____

Which ones:

Botox	Dermal Fillers	Microdermabrasion
Chemical Peel	Juvéderm	Restylane
Cosmetic Tattoo	Laser Hair Removal	Silicone Injections
Dermabrasion	Laser Skin Resurfacing	Other

Do you have any metal implants in your face or body? If so, where? _____

Any battery powered implants anywhere in your body? If so, where? _____

Any other health related concerns? _____

What are you hoping to achieve with the Microcurrent Rejuvenating Facial? _____

Please indicate any specific cosmetic concerns on the drawing below and add any comments about the areas. Please be precise and prioritize your concerns.



1. _____

2. _____

3. _____

4. _____

Any additional comments on the skin _____



Informed Consent for Treatment

DeBritt Ealey, L.Ac. VA License #0121000524

I hereby request and consent to the treatment of acupuncture and any other procedure within the scope of practice of Traditional Chinese Medicine at Striving for Health. I consent to treatment for myself (or for the client named below, for whom I am legally responsible) by DeBritt Ealey, L.Ac. and/or any other licensed acupuncturists who now or in the future may treat me while employed by, working, or associated with Striving for Health or serving as back up for DeBritt Ealey at any location.

I understand that methods of treatment within the scope of Traditional Chinese Medicine may include, but are not limited to: acupuncture (treatment with needles), acupressure point stimulation (manual or external device), electrical stimulation (microcurrent), moxibustion (indirect or direct application of heat to acupuncture points or needles), cupping (cups made of plastic or glass placed on the skin forming a suction), Tui-Na (Chinese massage), Gua Sha (Chinese dermal friction technique), Chinese herbal medicine, Chinese dietary therapy, and cosmetic acupuncture.

I have been informed that acupuncture is a generally safe method of treatment but that it may have some possible side effects, although rare, that can include bruising, numbness or tingling near the needle site that may last for a few days, dizziness or fainting, and needle sickness or shock. Most clients do not experience any complications with treatment.

Acupuncture/Acupressure/Cupping/ Gua Sha:

In very rare instances needles can break. Bleeding or bruising can be a side effect with acupuncture as well as possible nerve injury and needle shock. These side effects are rare, but possible. Bruising is a quite common side effect after a cupping or gua sha treatment on the body, but there is no bruising on the face from the modalities. Infection is another low but possible risk; however, this clinic ONLY uses sterilized single use needles and practices in a clean environment to reduce this chance even further. I understand that while this

document describes the major risks of treatment other side effects and risks may occur.

Herbal Therapy:

The herbs and nutritional supplements recommended (which can be from food, plants, animal, and mineral sources) are very safe within the practice of Traditional Chinese Medicine. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and/or tingling of the tongue. I understand that some herbs may interact with prescription medications, over-the-counter medications, or supplements; therefore, I will notify the acupuncturist named above if I am taking any medication or supplements concurrently with Chinese herbs. I understand that some herbs may be inappropriate during pregnancy.

Microcurrent (MENS) Treatments:

This is an extremely safe procedure. It has been used for over 50 year and is an FDA approved device. This therapy is used for pain issues (chronic and acute) and for Facial Rejuvenation treatments as an anti-aging procedure. Patients should not get this procedure if they have a pacemaker, insulin pump, are pregnant, have epilepsy or experience seizures, have a metal implant at treatment site, have phlebitis, thrombosis, or varicose veins, have cancer, experience cold sore breakouts, or have an active infection at the treatment site. For treatment of pain, several treatments may be needed before results are seen. For any holistic facial treatments, I understand that results are slower and less pronounced than with surgical or laser procedures, derma fillers or Botox, therefore I cannot expect the same level of change, or the immediate results received from these other therapies.

I understand that everyone responds differently to treatment, no matter what treatment is done, and results may vary. I will notify the acupuncturist and/or clinic if I am or if I become pregnant. Clients with severe bleeding disorders, diabetes, lymph edema, or infectious diseases such as HIV/AIDS, hepatitis, or tuberculosis should inform the acupuncturist prior to any treatment.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist's professional knowledge and judgment to determine and provide the best treatment for me, based upon the facts known at the time of treatment. I understand that results are not guaranteed. I understand that the acupuncturist is not providing Western (allopathic) medical diagnosis or care and that I should look to my Western primary care practitioner (ie:MD) for those services and for routine checkups.

I understand that the acupuncturist may review my patient records and lab reports.

By voluntarily signing below, I acknowledge that I have read or had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures within Traditional Chinese Medicine and have had the opportunity to ask questions about any of this with my acupuncturist. I intend this consent form to cover the entire course of my treatment for my present symptoms and conditions and for any future symptoms and conditions for which I seek treatment.

I also understand that there is a cancelation policy. If I cancel or reschedule my appointment within 24 hours of my scheduled time or don't show up for a scheduled appointment, I will be charged a \$75 fee.

Signed _____ Dated _____

Printed Name _____



Diagnostic Examination Release

As an acupuncturist licensed in the state of Virginia, it is required that I ask if you have received a diagnostic examination within the past six months by a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Chiropractic (DC) acting within the scope of his/her practice for the issue(s) that we will be addressing in this office.

I have seen a doctor about my issue(s): _____

If not, I am instructed to recommend that you get a diagnostic examination by a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Chiropractic (DC) acting within the scope of his/her practice for the issue(s) that we will be addressing in this office.

I have read and understand this information.

Signature

Date

**American Acupuncture Council Informed Consent for
Microcurrent Facial Treatment**

Patient Name: _____

Acupuncturist: DeBritt Ealey, L.Ac. Clinic Name: Striving for Health

Consent: I hereby request and consent to Microcurrent facial treatment by the acupuncturist named above and/or other licensed acupuncturists who now, or in the future, treat me while employed by, working or associated with, or serving as back-up for, the acupuncturist named above, including those working at the clinic or office listed above or any other office or clinic whether signatories to this form or not. I understand that Microcurrent treatment is not a surgical procedure and is in no way intended as a substitute for cosmetic surgery.

Type of Care: I have had an opportunity to discuss with the acupuncturist named above the nature and purpose of the Microcurrent treatment to which I am consenting. I understand that a Microcurrent treatment involves the placing of electronic probes to the face, neck and body, and that according to the theory of Traditional Chinese Medicine (TCM) the placing of these probes is designed to facilitate the flow of Qi (energy) along meridians or pathways throughout the entire body. A description of the specific type of Microcurrent care currently contemplated follows:

Facial Microcurrent Treatment

I understand that my treatment may be modified to address: 1) Changes in my condition, 2) Changes in my desired results, or 3) Changes in the professional standards of acupuncture care. I understand, and agree to adjustments in my treatment as needed to optimally address my well being, my objectives, and to take advantage of the full range of care options for me.

Potential Benefits: I understand that the purpose of Microcurrent treatment is to create a younger and more vibrant appearance by properly balancing the flow of Qi. This may include enhanced skin tone, improved luster of complexion, decreased puffiness around the eyes, elimination or reduction of fine wrinkles, improved muscle tone, a firming of sagging skin, and a lessening of the visible signs of aging. However, I understand that as with all TCM care, Microcurrent treatment involves a gradual, healthful process that is customized for each individual, and that results may vary.

No Guarantee: I understand that results are not guaranteed. My questions regarding longevity of results and potential changes in my facial appearance have been answered. I understand that although good results are hoped for, there is no guarantee or warranty, either expressed or implied, of the results that may be obtained.

Risks of Microcurrent: I understand that every procedure involves a certain amount of risk, including Microcurrent treatments. Some of the more common complications are

listed immediately below. I understand and am informed that even though the majority of patients do not experience these complications, problems may arise for me:

- **Bleeding and Bruising:** As with acupuncture in general, some minor bleeding may occur if using needles with microcurrent. This is normal and usually will not leave a bruise. Occasionally, a bruise or a hematoma may appear. With bruising, it is important that you wear sunscreen when going outside. Topical and internal remedies will be discussed to address bruising. If swelling persists, I understand, I should call my provider immediately.
- **Infection:** Infection at the probe site is very rare after treatment because the probe does not break the skin. If you suspect infection at the probe site (i.e. redness, swelling or warm to the touch), please call me. Additional treatment or referral to your M.D. may be necessary.
- **Damage to Deeper Structures:** In certain systems, deeper structures such as blood vessels, nerves and muscles are rarely damaged during the course of a Microcurrent treatment procedure. If this does occur, the injury may be temporary or permanent.
- **Asymmetry:** All facial structures are naturally asymmetrical. Results may vary from side to side due to the natural asymmetry, previous injuries on one side of the body, or severity of symptoms from one side or the other.
- **Nerve Injury:** Injury to the motor or sensory nerve very rarely results from Microcurrent treatments. Nerve injuries may cause temporary or permanent loss of facial movements and feeling. Such injuries may improve over time. Injury to the sensory nerves of the face, neck and ear regions may cause temporary or, more rarely, permanent numbness. Painful nerve scarring is extremely rare.
- **Allergic Reactions:** In rare cases, local allergies to topical preparations have been reported. Allergic reactions may require additional treatment or discontinuation of treatment.
- **Delayed Healing:** Delayed healing is a rare complication. Smoking and certain health conditions such as diabetes and chronic fatigue syndrome, to name a few, may delay the healing response of any of the aforementioned risks.
- **Unsatisfactory Results:** There is the possibility of a poor result from a Microcurrent procedure. You may be disappointed with the results.
- **Unsatisfactory Results:** I understand that I am not having a surgical procedure. The alternatives, risks, and comparisons of surgical procedures versus Microcurrent have been discussed with me and outlined in this document. Should I have any further questions, I will discuss them with my provider before treatment begins.
- **Long Term Effects:** Following Microcurrent treatments, changes in facial appearance may occur as the result of the normal process of aging, weight loss or gain, sun exposure, stress, illness, or other circumstances not related to Microcurrent. It has been explained that following lifestyle and dietary instructions may enhance the longevity of the Microcurrent treatment while non-compliance will adversely affect the longevity of the Microcurrent treatment. Additional, future treatments may be necessary to maintain the results.
- **Unforeseeable Impacts:** There are many variable conditions, in addition to the risks and potential complications enumerated that may influence the long term result from Microcurrent. While the complications cited are the ones particularly associated with Microcurrent, this is not an exact science, and other less common complications may arise. Should these or other complications occur, other treatments might be necessary.

Alternative Treatment: I understand that other alternatives exist for cosmetic care including but not limited to surgery, such as a surgical facelift, chemical face peels, or liposuction. I realize that there are also risks and potential complications associated with these alternative forms of treatment.

Health Insurance/Financial Responsibility: I understand that most health insurance does not cover the cost of the Microcurrent treatments or complications resulting from such treatments. Please contact your insurance if you have any questions about coverage. Depending on whether any or all of the cost of Microcurrent is covered by an insurance plan, I will be responsible for charges not so covered.

Unforeseen Conditions: I understand that there are several styles or methods of facial, cosmetic, or rejuvenation acupuncture and I have been informed that during the course of Microcurrent treatments, unforeseen conditions may necessitate different procedures than those listed above.

Agreement and Continuous Effect: I have read, or have had read to me, the above consent. It has been explained to me in a way that I understand: a) The risks involved with Microcurrent, b) That I have alternatives available to me for cosmetic improvements, and c) What protocols will be used in connection with treatment. I have also had an opportunity to ask questions regarding Microcurrent treatment, and I am satisfied that all my questions have been answered. I acknowledge that no guarantee has been given to me by anyone as to the results that may be obtained. I authorize the release of medical information, when required. Finally, by signing below I acknowledge that I have been fully informed about, and agree to, Microcurrent treatments. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature:

(Or Patient Representative)

(Indicate relationship if signing for patient)

Office Signature: