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Yuan College Facial Acupuncture Case History Record Sheet

for Student Practitioners in Training

To be completed by case study participant prior to first treatment

Case Study Participant's Name:

Date of Birth:

Contact Number:

Email:

Practitioner (Student) Name:

Date of First Treatment:

1. Medical History

Please provide brief details of any relevant health conditions, past or present:

Allergies or sensitivities (including to metals, latex, essential oils)
Significant illnesses, surgeries, or injuries
Current medications
Blood disorders, bruising tendency, or anticoagulant use
Skin conditions (rosacea, eczema, acne, dermatitis, etc

History of migraines, sinus issues, or TMJ/jaw tension
Any neurological conditions (e.g., Bell's palsy, stroke, numbness)

2. Facial & Aesthetic History

Cosmetic acupuncture or microneedling
Botox or dermal fillers — date and area treated
Thread lifts, laser resurfacing, peels, or cosmetic surgery — type and date
Regular facials, facial massage, or skincare regime
Any recent facial trauma or infections

Please note: Certain procedures (such as Botox, fillers, or surgery) require a waiting period before facial acupuncture can safely be administered. Your practitioner will advise accordingly.

3. General Wellness

Description (educational tone):

Please rate and describe your current state of wellbeing across the areas below. This helps your practitioner tailor your treatments and track changes over your 10-session course.

Use the scale provided for each category, and add comments as relevant and appropriate.

1. Energy Levels **How would you rate your daily energy levels overall?** ***(1 = very low / fatigued, 10 = consistently high and balanced)***
Any patterns or times of day when energy drops or improves?
Comments

2. Sleep Quality **How would you rate the quality of your sleep?** ***(1 = poor / restless / difficulty staying asleep, 10 = deep, restorative, regular)***
Average hours of sleep per night and any sleep difficulties (insomnia, waking, vivid dreams, etc.)
Comments

3. Digestion **How would you rate your digestion and gut comfort?** ***(1 = sluggish, bloated, irregular / 10 = comfortable, regular, good appetite and elimination)***
Note any digestive patterns or sensitivities
Comments

4. Stress & Emotional Balance **How would you rate your current level of stress or tension?** ***(1 = very high stress / anxious, 10 = calm, grounded, emotionally balanced)***
Any common stress triggers or recent emotional challenges?
Comments

5. Hormonal or Menstrual Balance **How balanced do you feel hormonally?** ***(1 = very imbalanced, frequent symptoms / 10 = stable, symptom-free)***
Note any menstrual or hormonal symptoms.
Comments

6. Urogenital Health & Comfort **How balanced or comfortable do you feel in your urogenital system (bladder, pelvic area, urinary function, libido, reproductive comfort)?** ***(1 = frequent discomfort, imbalance, or symptoms / 10 = comfortable, balanced, symptom-free)***
Please note any relevant patterns or symptoms (e.g., frequency, urgency, retention, pain, pelvic tension, hormonal or sexual wellbeing)
Comments

7. Musculoskeletal Comfort **How comfortable or free does your body feel from muscular or joint tension?** ***(1 = frequent pain, tightness, or stiffness / 10 = relaxed and mobile)***
If anywhere, where do you feel discomfort and since when?
Additional comments

8. Overall Sense of Wellbeing **How would you describe your overall sense of wellbeing at present?** ***(1 = low vitality or emotional strain / 10 = balanced, content, and resilient)***
Comments

Any other comments:

4. Main goals for treatment

Facial acupuncture addresses the face as a reflection of the whole body and mind. You may wish to include:

- *Facial enhancement goals – tone, lines, puffiness, colour, radiance, etc.*
- *Psycho-emotional aspects – stress, tension, anxiety, mood, emotional expression.*
- *Physiological aspects – sleep, digestion, hormones, circulation, energy levels.*
- *Physical patterns / discomforts – e.g., headaches, jaw tension, sinus issues, chronic imbalance.*

Please share what you would most like to focus on or support through this course of treatments
Facial **Psycho-emotional** **Physiological** **Physical patterns/discomforts**

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5. Consent, Risks, and Acknowledgement

Please read and tick each box

I understand that:

	Facial acupuncture involves the insertion of fine needles into specific points on the face and body to support circulation, tone, and overall balance.
	Possible side effects may include minor bruising, redness, temporary swelling, lightheadedness, or tenderness at needle sites.
	Rare but potential risks include infection, allergic reaction, or prolonged bruising.
	My practitioner is a **student currently undertaking training** and will be supervised and/or guided by an experienced trainer as part of their course requirements.
	I have disclosed all relevant medical and aesthetic history to the best of my knowledge.
	I understand that the effects of facial acupuncture vary individually and no specific outcomes can be guaranteed.
	I consent to receive facial acupuncture as part of this course of treatment

Client Signature: _____

Date: _____

Practitioner Signature: _____

Date: _____