Rejuvenate!! Center

CHECK LIST FOR ACUPUNCTURE

1. Are you diabetic?	Yes	No
2. Are you on anti-coagulants?	Yes	No
3. Are you pregnant?	Yes	No
4. Do you bruise or bleed easily?	Yes	No
5. Does your skin break easily or appear shiny or very thin?	Yes	No
6. Have you ever had hepatitis or jaundice?	Yes	No
7. Do you take any steroids?	Yes	No
8. Do you have artificial heart valves or a pacemaker?	Yes	No
9. Do you have a heart complaint or take medication for a heart complaint?	Yes	No
10. Are you epileptic?	Yes	No
11. Do you have an allergy to metal?	Yes	No
12 Do you have an infection?	Yes	No
13. Do you have any immune system problems?	Yes	No
14. Do you have a history of tumor/CA ?	Yes	No
15. Are you a blood donor?	Yes	No
16. Do you have a history of fainting or blackouts?	Yes	No
17. Are you under investigation for any medical condition?	Yes	No

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Signature Date