

Rejuvenate!! Center

CHECK LIST FOR ACUPUNCTURE

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| 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 |

Signature

Date