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Cosmetic Acupuncture Questionnaire

Please describe your main skin complaint.

What improvements would you like to see?

Please describe any skin sensitivities or allergies.

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

Do you wear makeup daily? yes / no

Do you wear sunscreen daily? yes / no

Which procedures have you had, or are currently undergoing?
(Botox, collagen, laser, micro-dermabrasion, surgery, etc.) Please include dates.

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

- | | |
|---|---|
| <input type="checkbox"/> Bags / swelling under eyes | <input type="checkbox"/> Droopy eyelids |
| <input type="checkbox"/> Sagging face | <input type="checkbox"/> Premature graying of hair |
| <input type="checkbox"/> Jowls | <input type="checkbox"/> Dry skin |
| <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Lusterless skin |
| <input type="checkbox"/> Nasolabial (nose to mouth) | <input type="checkbox"/> Age spots |
| <input type="checkbox"/> Eyes (crowsfeet) | <input type="checkbox"/> Sun damage |
| <input type="checkbox"/> Lips | <input type="checkbox"/> Double chin |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Broken capillaries |
| <input type="checkbox"/> Vertical creases / furrows | <input type="checkbox"/> Tight jaw / teeth grinding |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Acne scarring |
| <input type="checkbox"/> Rosacea | <input type="checkbox"/> Protruding temporal veins |
| <input type="checkbox"/> Large pores | |

Please describe any other skin conditions / issues you would like to discuss.

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