SELF-ASSESSMENT

Please complete and return this form to the front office before your consultation.

NAME: _____ DATE OF BIRTH: _____ DATE: _____

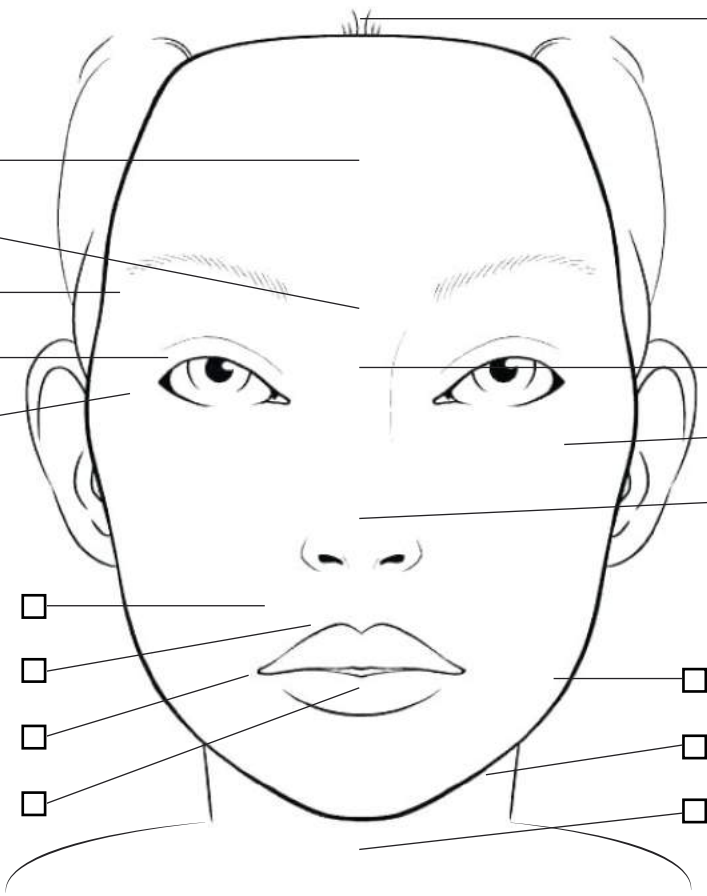
What brings you in today? _____

Other than the services we have already provided for you, what additional services would like to learn about? Please check all that apply.

☐ Skin care advice	☐ Facial veins	☐ Scar revision
☐ Skin care products	☐ Facial redness	☐ Breast size
☐ Facial injectables/fillers	☐ Brown spots/age spots/freckles	☐ Abdominal area
☐ Facial fine lines/wrinkles	☐ Drooping brow	☐ Hips
☐ Thin lips	☐ Drooping eyelids	☐ Legs
☐ Length of eyelashes	☐ Nose size or shape	☐ Facial contouring
☐ Fullness of eyelashes	☐ Facial fullness/drooping	☐ Body contouring
☐ Darkness of eyelashes	☐ Mole removal	☐ Unwanted hair
☐ Chemical peel	☐ Neck wrinkles	
☐ Blotchy skin	☐ Make up	

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



☐ Hair Loss and/or Thinning

☐ Forehead Lines

☐ Frown Lines

☐ Hollow Temples

☐ Inadequate Lashes

☐ Crow's Feet

☐ Overall Skin Appearance and Texture

☐ Nose Hump or Dip

☐ Flattened Cheeks

☐ Nose Tip

☐ Nasolabial Folds

☐ Vertcal Lip Lines (Smoker's Lines)

☐ Oral Commisures (Corner of the Mouth)

☐ Thin/Uneven Lips

☐ Weak Jawline

☐ "Double Chin"

☐ Neck & Chest Lines & Wrinkles

Your Top 3 Areas of Concern:

1.

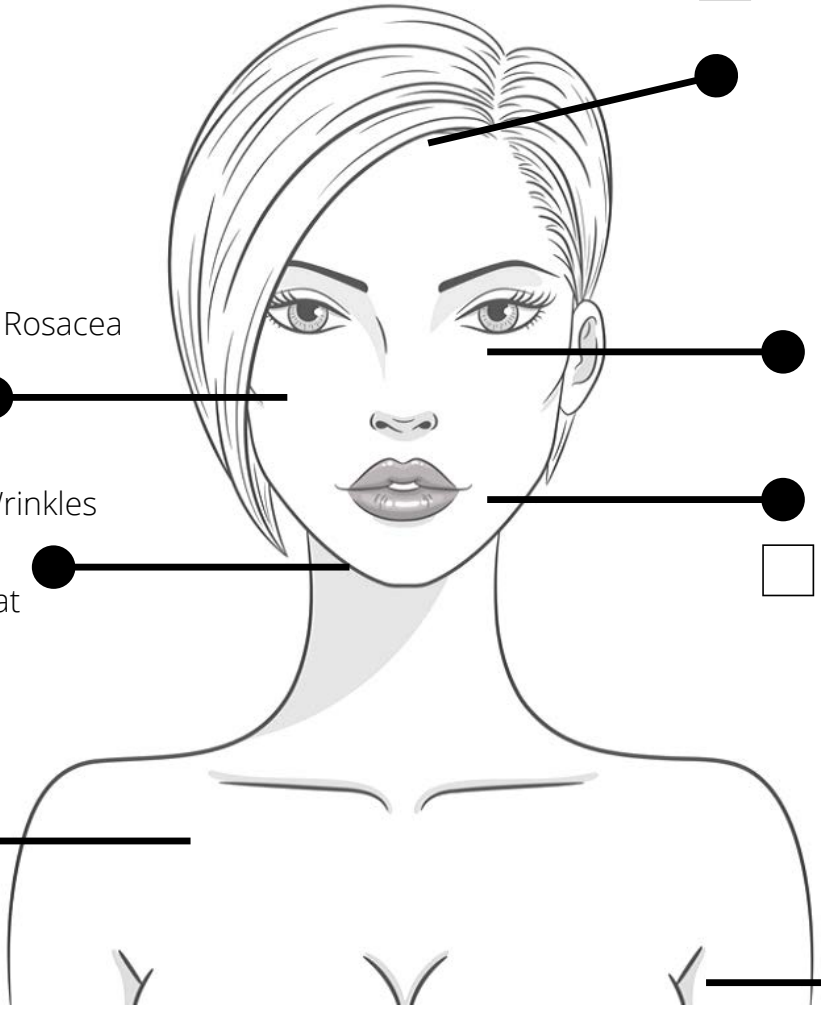
2.

3.

Your Treatment Plan Timeline (FOR OFFICE USE ONLY)

Name: _____

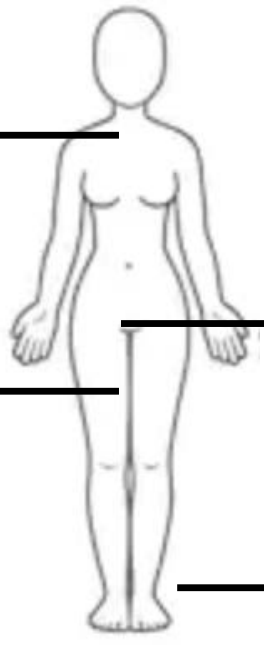
Email: _____



- [ ] Pore Size
- [ ] Hair Loss
- [ ] Acne / Scarring
- [ ] Volume Loss
- [ ] Blood Vessels / Rosacea
- [ ] Fine Lines / Wrinkles
- [ ] Under Chin Fat
- [ ] Sun Spots
- [ ] Dark Circles
- [ ] Crows Feet
- [ ] Eye Bags
- [ ] Lip Volume or Fullness

Frequent Sweating

- [ ] Underarms
- [ ] Hands
- [ ] Feet



- [ ] Excess Weight
- [ ] Muscle Toning
- [ ] Loose Skin
- [ ] Stretchmarks
- [ ] Loose skin above the knee
- [ ] Cellulite
- [ ] Frequent Urination
- [ ] Dryness / Painful Intercourse
- [ ] Vaginal Laxity
- [ ] Hair Removal

SELF ASSESSMENT - BODY

DATE: _____

FULL NAME: _____ DATE OF BIRTH: _____

WHAT BRINGS YOU IN TODAY? _____

PLEASE CHECK WHAT CONCERNS YOU HAVE:

CONCERNS

- ☐ Excess Fat/Fullness
- ☐ Excess/Loose/Saggy Skin
- ☐ Lack of Muscle Tone
- ☐ Lack of Contour/Definition
- ☐ Volume Loss
- ☐ Stretch Marks
- ☐ Cellulite
- ☐ Unwanted Hair
- ☐ Skin Texture
- ☐ Age/Sun/Brown Spots
- ☐ Excessive Sweating

List Any Other Concern(s) or Issue(s) Below:

_____

_____

_____

PLEASE CIRCLE OR MARK THE AREAS OF CONCERN:

By sharing how you see yourself, we can best evaluate your goals and help you select appropriate procedures for optimal results.