SELF - ASSESSMENT

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

NAME: _____ DATE OF BIRTH: _____ DATE: _____

WHAT BRINGS YOU TODAY?: _____

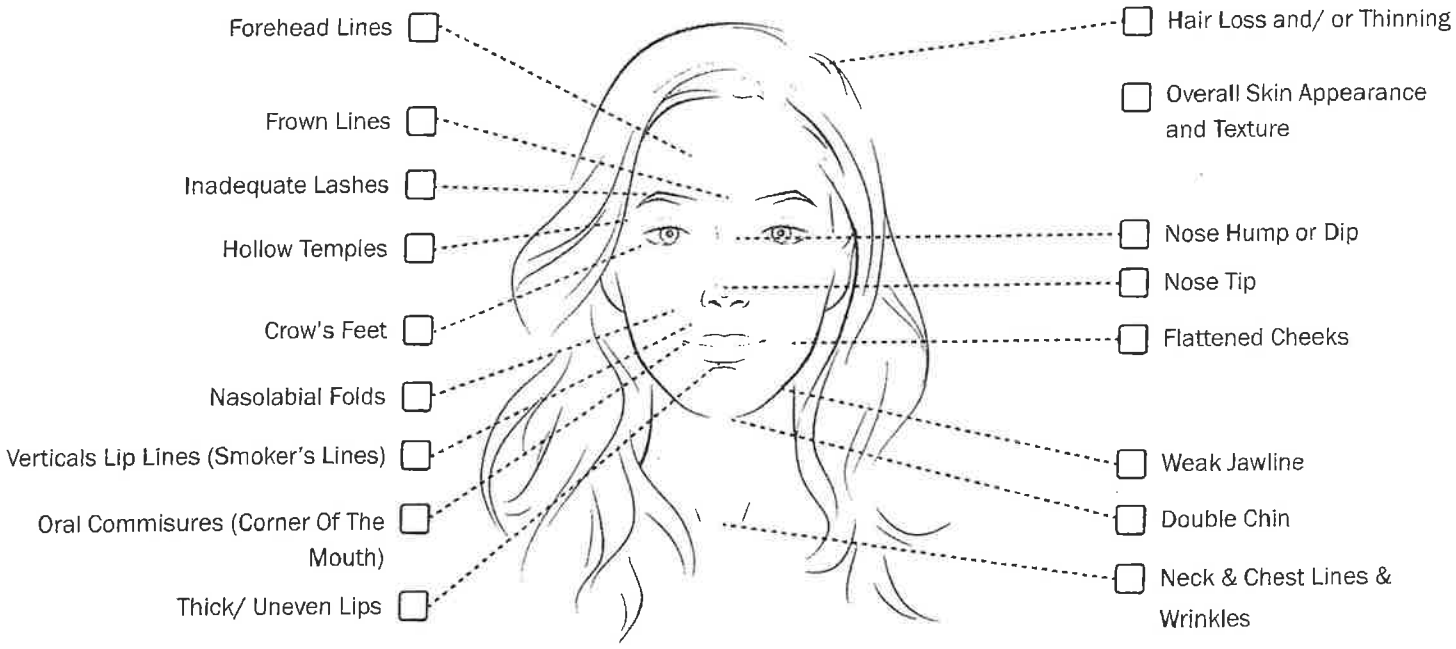
Other than the services we have already provided for you, what additional services would like to learn about?

Please check all that apply.

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

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



Your Top 3 Areas Of Concern

1.

2.

3.

Your Treatment Plan Timeline (FOR OFFICE USE ONLY)

SELF - ASSESSMENT - BODY

NAME: _____ DATE OF BIRTH: _____ DATE: _____

WHAT BRINGS YOU TODAY?: _____

Please check what concerns you have

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

List any other concern(s) or Issue(s) Below:

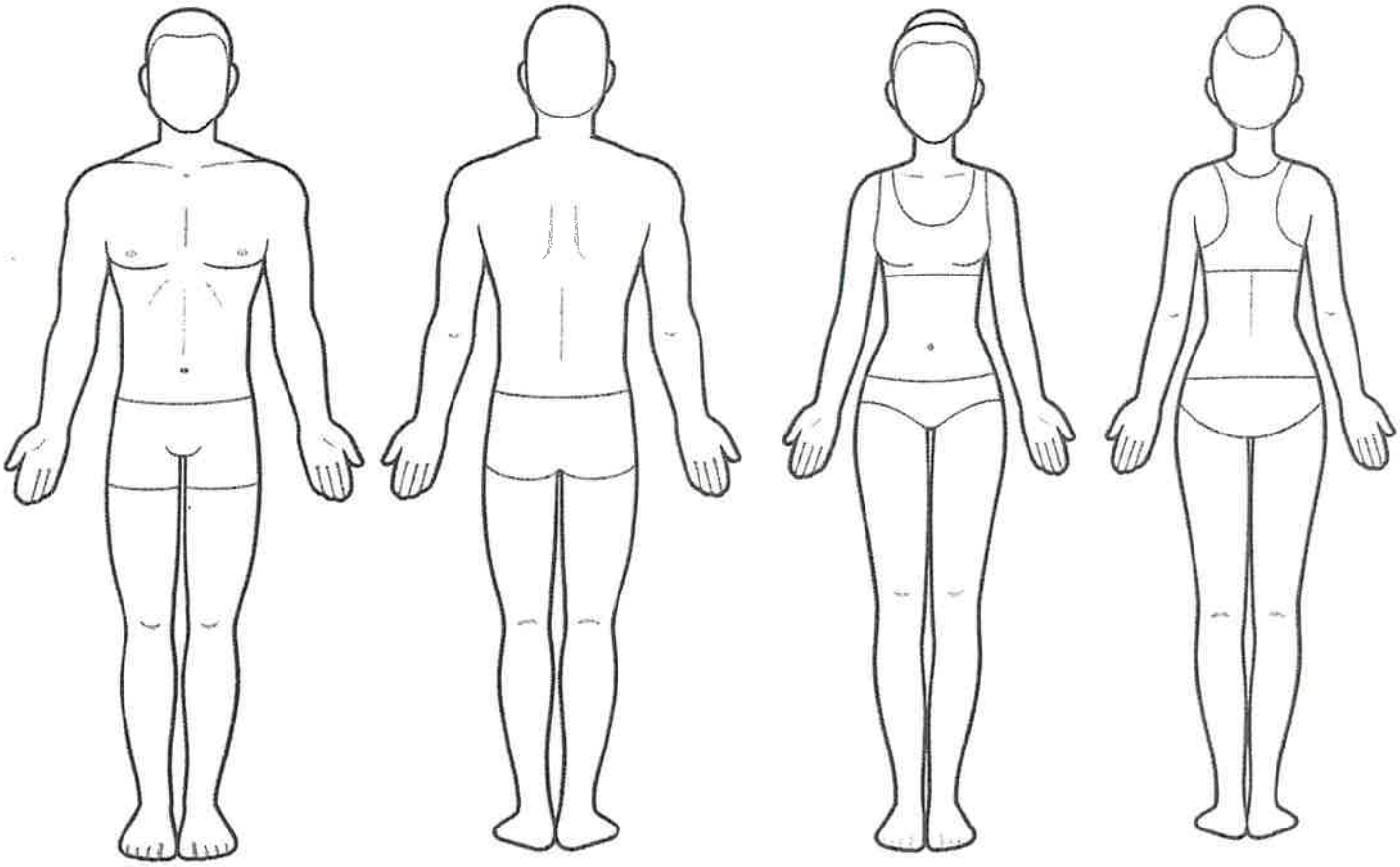
_____

_____

_____

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



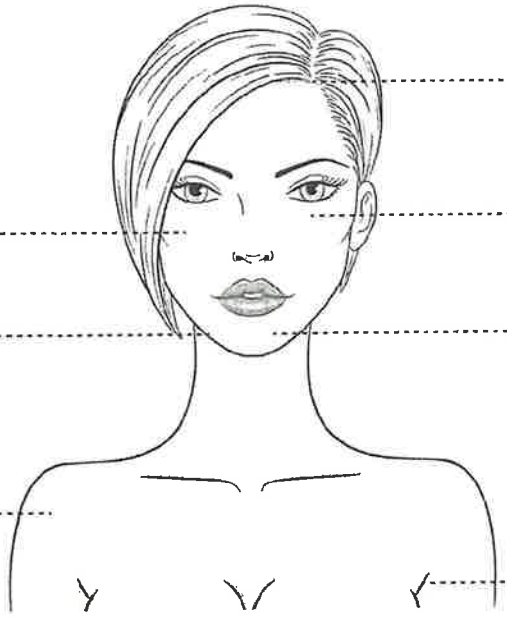
SELF - ASSESSMENT

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

NAME: _____ EMAIL _____

Select which areas of the face and body concern you on the diagrams below.

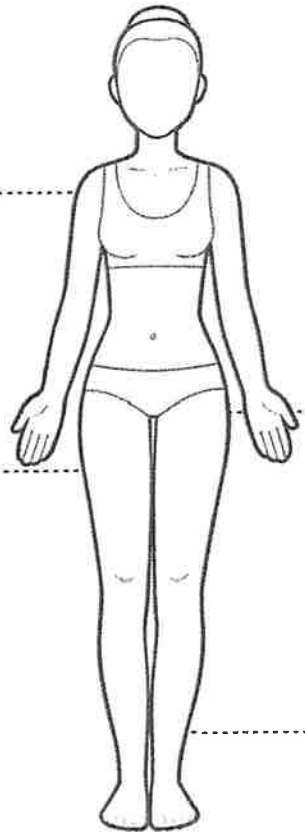
By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you



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

FREQUENT SWEATING

- ☐ Feet
- ☐ Hands
- ☐ Underarms



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