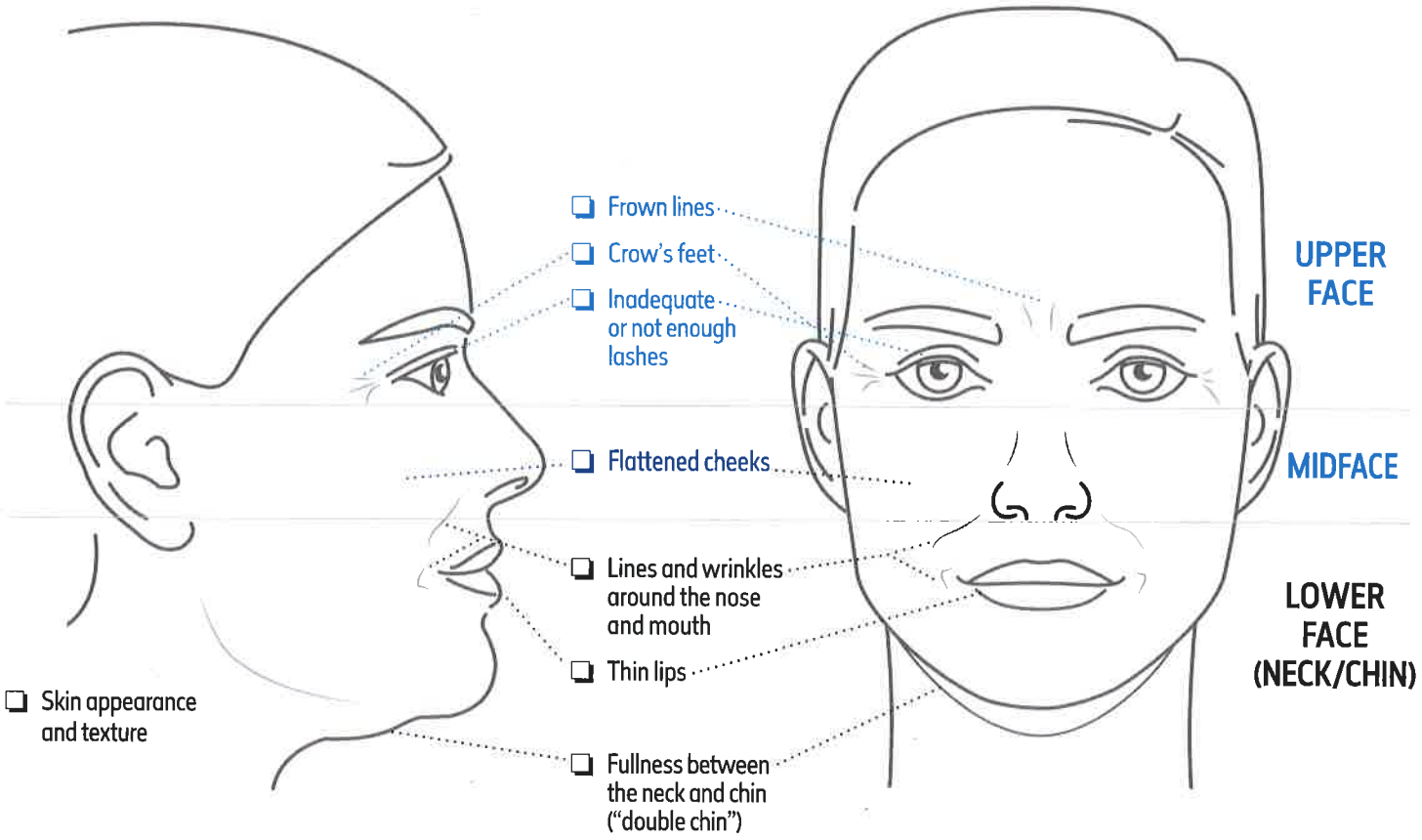
SELF-ASSESSMENT

NAME: _____ DATE OF BIRTH: _____ DATE: _____

What brings you in today? _____

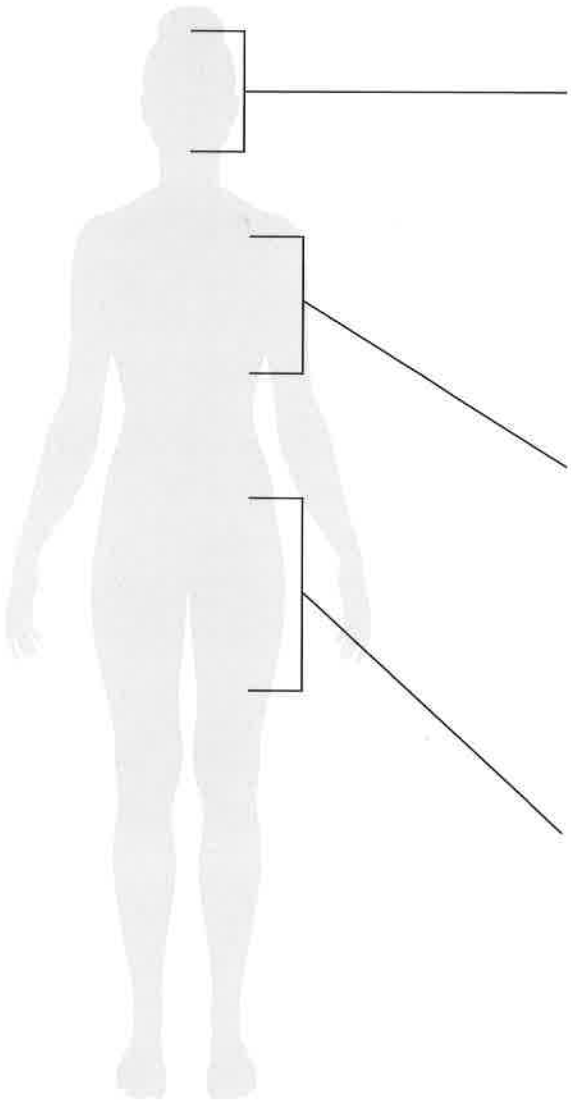
Select which areas of the face concern you on the diagram below.

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



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

Please check any areas of concern



Face

____ Lines and wrinkles on your face

____ Cheeks

____ Lips

____ Chin

____ Sunspots/age spots/brown spots

____ Other _____

Breasts

____ Sagging, deflated breasts

____ Uneven breasts

____ Breast size

____ Breast implants that need replacing

____ Scars

____ Other breast issues _____

Body

____ Loose, wrinkly tummy

____ Bulging tummy

____ Excess fat on your thighs

____ Body contouring

Tell us about yourself

Name: _____

City: _____ State: _____ Zip: _____

Phone number: _____

Email: _____

Birthday: _____

How would you prefer we communicate with you?

Email: _____ Text: _____ Phone call: _____ US mail: _____

What is the reason for your visit today? _____