MY CONSULTATION GOALS

First Name: _____ Last Name: _____

DOB: _____ Phone #: _____

Address: _____ City: _____ Zip Code: _____

Email Address: _____

How did you hear about us? _____ Today's Date: _____

1. **Please list the top 3 problems on your "Hit List" that you would like to see improved after treatment/s. (you may list fewer)**

FACE	**BODY**
1) _____	2) _____
3) _____	3) _____
4) _____	4) _____

2. Please list the next 4 concerns (if applicable) you would want to address during your consultation:

1) _____

2) _____

3) _____

4) _____

3. What adjective(s) best describe your face or body now?

For example: **FACE:** *rested, youthful, fresh OR tired, angry, sad, droopy, wrinkly*

BODY: *tight, firm, balanced OR droopy, saggy, loose, disproportionate*

FACE: _____

BODY: _____

4. How many years younger / fresher would you like to look? (Please circle that which applies)

O 0-5 years O 6-10 years O 11-15 years O >15 years

5. How much money do you want to spend to achieve your goals? (Please circle that which applies)

O 0- $5000 O $6000 - $10,000 O $11,000 - $15,000 O $16,000 - $20,000

6. How much time off can you devote to your enhancement? (Please circle that which applies)

O 0-1 weeks O 1-3 weeks O > 3 weeks

7. What non-surgical skin concerns bother you? (Please circle those that apply)

O Wrinkles O Pores O Texture O Brown Pigmentation

O Dark Circles O Cellulite O Red Vessels O Other: _____

8. What non-surgical treatments have you had? (Please circle those that apply)

O Botox O Filler (Restylane/Juvederm ect) O IPL/Photofacial O Skin Lightening

O Laser Vein Treatment O Laser Hair Removal O Cellulite Treatments O Laser Skin Tightening O Laser Skin Resurfacing O Sclerotherapy O Medical Facials

Other: _____

9. What non-surgical treatments would you be interested in having? (Please circle those that apply)

O Botox O Filler (Restylane/Juvederm ect) O IPL/ Fotofacial O Laser Hair Removal
O Cellulite O Laser Skin Tightening O Laser Skin Resurfacing O Medical Facial O Acne
O Age Spot O Face/Body Contouring O Weight Loss O Spider Vein Treatment

O Other: _____ What was the outcome: _____

Patient Signature: Date

PRACTIONER NOTE: ----------
