

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**What are your areas of concern?**

(Please check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Frown lines between the brows           | <input type="checkbox"/> Fine lines and wrinkles         |
| <input type="checkbox"/> Significant lines around nose and mouth | <input type="checkbox"/> Rough skin texture              |
| <input type="checkbox"/> Tired-looking skin                      | <input type="checkbox"/> Sagging Skin                    |
| <input type="checkbox"/> Facial/Body hair                        | <input type="checkbox"/> Age Spots                       |
| <input type="checkbox"/> Acne                                    | <input type="checkbox"/> Hyperpigmentation/Sun Damage    |
| <input type="checkbox"/> Freckles                                | <input type="checkbox"/> Dark circles under the eyes     |
| <input type="checkbox"/> Excessive Sweating                      | <input type="checkbox"/> Wrinkles/Loose skin around eyes |
| <input type="checkbox"/> Dry Skin                                | <input type="checkbox"/> Sparse or Thinning Eyelashes    |
| <input type="checkbox"/> Other, please specify _____             |  |

What facial products are you using daily? Are you happy?

Do you have facials, peels or microdermabrasion on a regular basis?

Have you ever received cosmetic treatments such as lasers, facial fillers or botox?

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

<i>Younger Than</i>		<i>True Age</i>		<i>Older Than</i>
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

<i>Not Concerned</i>	<i>Somewhat Concerned</i>	<i>Very Concerned</i>
1	2 3	4 5

YES, I would like to receive emails about upcoming events and promotions!

Email: \_\_\_\_\_

Thank You!