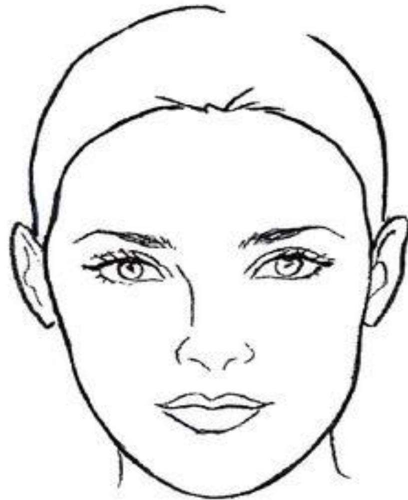
Self-Assessment

Date: ___________________ **Name:** _______________________________________

What brings you in today? ____

Circle areas of concern or you would like more information about on the figures below. By sharing how you see yourself and your desires, we can best evaluate your goals and help select an appropriate treatment with you.



Upper Face

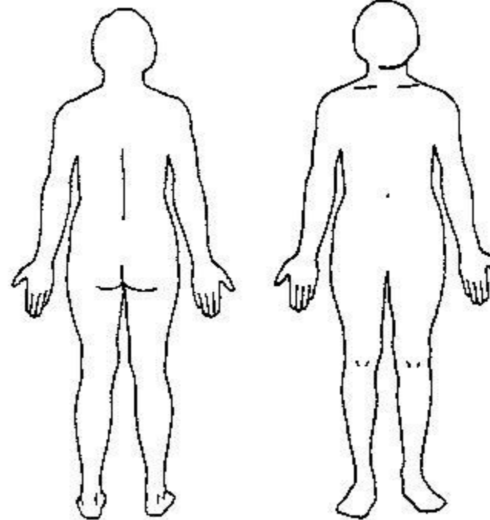
- *Forehead Lines*
- *Frown Lines*
- *Crow's Feet (smile lines)*
- *Sparse Lashes/Brows*
- *Hollowing Under Eyes*
- *Under Eye Puffiness/Bags*

Midface

- *Flattened Cheeks/Volume Loss*
- *Lines/Wrinkles Around Nose*

Lower Face

- *Lines/Wrinkles Around Mouth*
- *Thin Lips*
- *Corners of Mouth*
- *Double Chin*
- *Jowls*
- *Neck Lines or Wrinkles/Loose Skin*



Body

- *Hair Removal*
- *Body Shaping/Fat Melting*
- *Cellulite*
- *Brown/Red Spots*

Wellness

- *B12/Turbo Shots for Energy/Weight Loss*
- *IV Nutritional Therapy*
- *Medical Weight Loss*
- *Bio-Identical Hormone Replacement*
- *Chronic Fatigue*
- *Thryoid*
- *Autoimmune*

Overall Skin Appearance

- *Texture*
- *Acne*
- *Scars*
- *Facial Hair*
- *Sagging/Loose Skin*
- *Brown (pigment) or Red Spots*