Patient Intake Form

Name:

Age:

Sex:

- ○ Male
- ○ Female

How would you describe your skin?

- ○ SENSITIVE
- ○ RESILIENT
- ○ NORMAL

AREAS YOU'D LIKE TO IMPROVE
What are your concerns that you would like to improve? (select all that apply)

- ☐ PIGMENT
- ☐ HAIR LOSS
- ☐ TEXTURE & DULLNESS
- ☐ AGING (fine lines, wrinkles)
- ☐ BREAST LIFT
- ☐ UNDEREYES
- ☐ ACNE SCARS
- ☐ VOLUME LOSS
- ☐ WEIGHT LOSS
- ☐ ROCASEA
- ☐ FACIAL BALANCING & ASYMETRY
- ☐ LOW ENERGY

Any other concerns not listed above?

How long have you been concerned with these issues?

Has this ever made you feel discouraged or stressed?

PREVIOUS EFFORTS

List all treatments you have tried:

List all topical products you have tried:

YOUR FEARS & CONCERNS

What are you afraid this could affect if left unaddressed? (select all that apply)

- [ ] Confidence
- [ ] Career Opportunities
- [ ] Social Life/Relationships
- [ ] Weight gain/Health issues
- [ ] Freedom/Future abilities

On a scale of 1-10, how concern are you about your current issues?

On a scale of 1-10, how ready are you to start making changes toward your goals?

Do you feel uncomfortable taking pictures or selfies? If so, why?

Are there times when you avoid social events or photos because of how you feel about your appearance?

What factors have kept you from starting treatments?

- [ ] Cost/Finances
- [ ] Unsure about which treatment is right for me
- [ ] Nervous about discomfort or downtime
- [ ] Haven't had the time
- [ ] Other;

If Other, please provide detail: