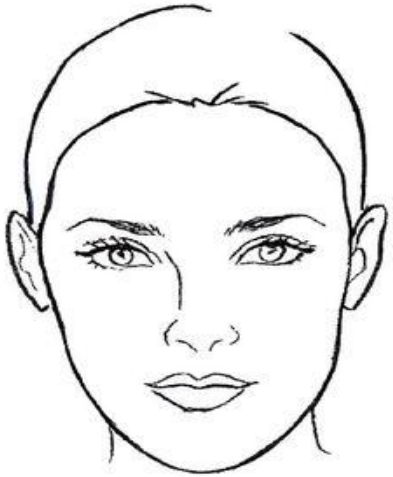
Self-Assessment

Date: _____ Name: _____

What brings you in today? _____

Circle areas of concern or services 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 the most appropriate treatment(s) with you.



Upper Face

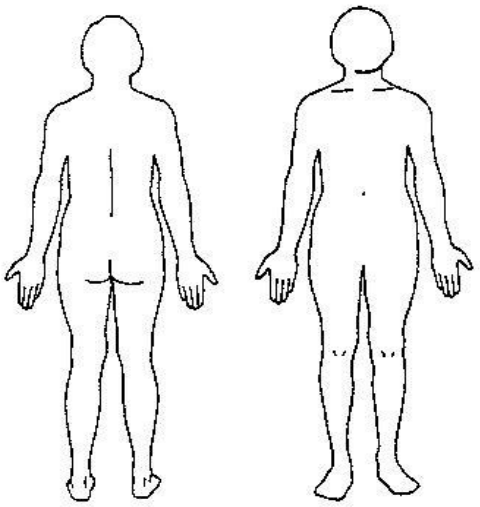
- *Forehead Lines*
- *Frown Lines*
- *Crow's Feet (smile lines)*
- *Sparse Lashes/Brows*
- *Hollowing Under Eyes*
- *Under Eye Puffiness/Bags*

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 Reduction*
  Area(s): _____
- *Cellulite*
- *Breast or Butt Lift*

Wellness

- *B12/Turbo Shots for Energy/Weight Loss*
- *IV Nutritional Therapy*
- *Medical Weight Loss*
- *Bio-Identical Hormone Replacement*
- *Chronic Fatigue*
- *Thryoid*
- *Autoimmune*
- *Wellness/Functional Medicine*
- *Pain*
- *Mold - Lyme - Chronic Infection*

Overall Skin Appearance

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

Male/Female Enhancement

- *Incontinence*
- *Libido*
- *Orgasm*
- *Tightening (female) or Size (male)*
- *Erectile Dysfunction*

Regenerative Medicine

- *Joint Pain*
- *Back pain*
- *Ozone*
- *PRP and/ or Exosomes*