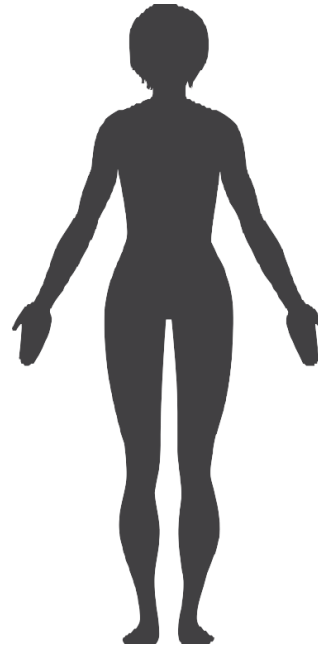
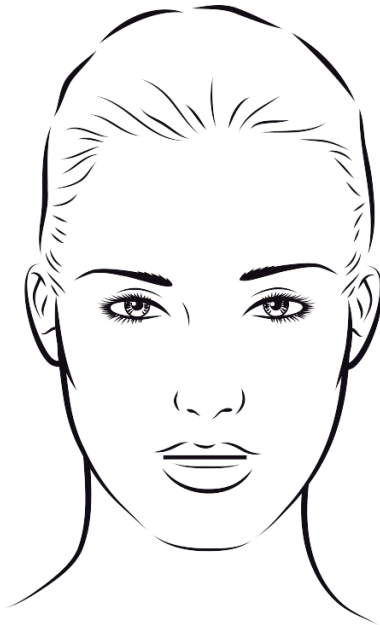


Name:	What is the reason for your visit today?
Date:	

### Areas of concern for me:

Please check all that apply and circle the areas on the diagram.



<u>SKIN</u>	<u>BODY</u>	<u>MEDICAL</u>
<input type="checkbox"/> Fine lines, wrinkles <input type="checkbox"/> Frown lines <input type="checkbox"/> Deep lines around nose and mouth <input type="checkbox"/> Texture of skin <input type="checkbox"/> Pigmentation <input type="checkbox"/> Age spots, sun spots <input type="checkbox"/> Large pores <input type="checkbox"/> Acne/Acne scars <input type="checkbox"/> Sagging loose skin <input type="checkbox"/> Crow's Feet <input type="checkbox"/> Unwanted hair <input type="checkbox"/> Redness, Rosacea <input type="checkbox"/> Dry, sensitive skin <input type="checkbox"/> Enlarged blood vessels <input type="checkbox"/> Other	<input type="checkbox"/> Unwanted hair <input type="checkbox"/> Skin discoloration <input type="checkbox"/> Cellulite <input type="checkbox"/> Excess fat <input type="checkbox"/> Muffin top, love handles <input type="checkbox"/> Bra roll, arm flab <input type="checkbox"/> Thighs <input type="checkbox"/> Weight and/or dress size <input type="checkbox"/> Loose, sagging skin <input type="checkbox"/> Neck, jowls <input type="checkbox"/> Stretch marks <input type="checkbox"/> Freckles, sun spots <input type="checkbox"/> Spider veins <input type="checkbox"/> Varicose veins <input type="checkbox"/> Back acne <input type="checkbox"/> Other	<input type="checkbox"/> Energy, stamina <input type="checkbox"/> Focus, brain foginess <input type="checkbox"/> Memory <input type="checkbox"/> Sleep quality <input type="checkbox"/> Moodiness, anxiety <input type="checkbox"/> Low libido <input type="checkbox"/> Sexual arousal <input type="checkbox"/> Intensity of orgasms <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Vaginal tightness <input type="checkbox"/> Vaginal discomfort during sex <input type="checkbox"/> Bulky appearance in swimsuit or yoga pants <input type="checkbox"/> Rapid weight gain <input type="checkbox"/> Other



## Female Interest Questionnaire

Please list in order of importance your top 3 areas of concern:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### I am interested in the following services:

Please check all that apply.

<u>SKIN</u>	<u>BODY</u>	<u>MEDICAL</u>
<input type="checkbox"/> HydraFacial MD	<input type="checkbox"/> Vanquish Body Contouring	<input type="checkbox"/> HCG Weight Loss
<input type="checkbox"/> Chemical Peels	<input type="checkbox"/> Protégé Skin Tightening	<input type="checkbox"/> B-12 Injections
<input type="checkbox"/> Microneedling/Dermapen	<input type="checkbox"/> Exilis Body Sculpting/Cellulite Reduction	<input type="checkbox"/> Bio-Identical Hormone Optimization
<input type="checkbox"/> BBL/PhotoFacial	<input type="checkbox"/> Laser Hair Reduction	<input type="checkbox"/> Vaginal Rejuvenation
<input type="checkbox"/> MicroLaserPeel	<input type="checkbox"/> Laser Vein Treatments	<input type="checkbox"/> Labiaplasty
<input type="checkbox"/> Profractional Laser Peel	<input type="checkbox"/> Resolution Cellulite system	<input type="checkbox"/> Liposuction
<input type="checkbox"/> Protégé Skin Tightening		<input type="checkbox"/> G-Spot Injection
<input type="checkbox"/> BOTOX Cosmetic		
<input type="checkbox"/> Dermal Fillers (i.e. Juvederm, Restylane)		
<input type="checkbox"/> Laser Hair Reduction		
<input type="checkbox"/> Skin Care Products		
<input type="checkbox"/> Latisse Lash Growth		

Please list in order of importance your top 3 services you are interested in learning more about:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### Notes:

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