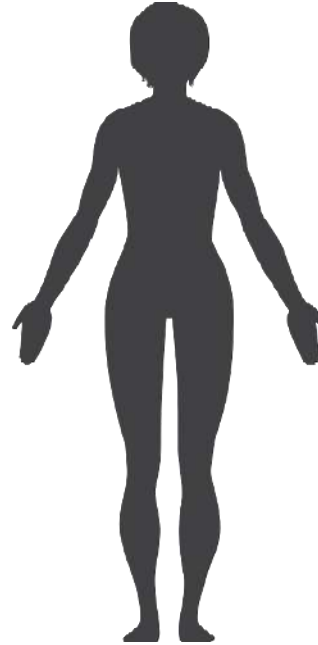
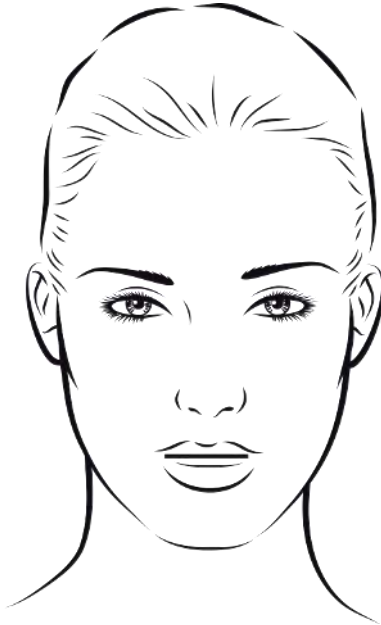


Name:	What is the reason for your visit today?
Date:	

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