



# Aesthetics Skin Care & Treatment Questionnaire

First/Last Name: _____	DOB: _____	Date: _____
<input type="checkbox"/> Please send me monthly/specials via Email: _____.		
<b>Are you interested in learning more about our Aesthetics Treatments?</b> Yes ____ Not at this time ____		
<b>We're here for all your skin care needs!</b>		

**When looking in the mirror, I am:**

- ☐ Not concerned about the appearance of my skin
- ☐ Somewhat concerned about the appearance of my skin
- ☐ Very concerned about the appearance of my skin

**I'm interested in learning more about the following treatments to improve the following areas:**

- ☐ Fine Lines/Wrinkles
- ☐ Texture/Crepey Skin
- ☐ Stretch Marks/Birthmark Reduction
- ☐ Neck Fullness (Double Chin) Reduction
- ☐ Sun/Age Spot Treatment
- ☐ Acne and Acne Scarring
- ☐ Rosacea/Red Facial Vessels
- ☐ Spider Vein Treatment
- ☐ Thinning Eyelashes (length/fullness)
- ☐ Hair Reduction Laser Treatments: What area(s) of the body? \_\_\_\_\_
- ☐ Advanced Skin Care Regimen
- ☐ Thinning or Balding Hair
- ☐ Other, please specify: \_\_\_\_\_

**What is your current skin care Routine? (i.e: Cleanser, SPF, moisturizer)?**

**AM:** \_\_\_\_\_

**PM:** \_\_\_\_\_

**Would you like to schedule a Free 15 minute, Complimentary Consult to discuss solutions to your concerns?**

- ☐ **Yes, today if possible**      ☐ **Yes, at a later date**      ☐ **Not at this time, thank you**

**How did you hear about us?**

- |   |   |
|---|---|
| <input type="checkbox"/> Doctor               | <input type="checkbox"/> Magazine/Advertisement |
| <input type="checkbox"/> Friend/Family: _____ | <input type="checkbox"/> Social Media           |
| <input type="checkbox"/> Online/Website       | (Facebook/Instagram/Twitter)                    |

**Office Use Only:**

- ☐ Patient Scheduled for 15 min Consult
- ☐ Patient Scheduled Cosmetic Appointment with a Provider: \_\_\_\_\_