

BELLADERM MEDSPA
PERSONAL TREATMENT ASSESSMENT



Name: _____

Date : _____

What areas of interest or concern do you have? Please check all that apply.

| | | |
|---|--|---|
| <input type="checkbox"/> Facial fine lines/wrinkles | <input type="checkbox"/> Facial veins | <input type="checkbox"/> Neck wrinkles |
| <input type="checkbox"/> Frown lines between brows | <input type="checkbox"/> Leg veins | <input type="checkbox"/> Length/fullness of eyelashes |
| <input type="checkbox"/> Wrinkles/lines around nose/mouth | <input type="checkbox"/> Facial redness | <input type="checkbox"/> Home skin care regime |
| <input type="checkbox"/> Thin lips | <input type="checkbox"/> Brown spots/age spots/freckle | <input type="checkbox"/> Stress incontinence |
| <input type="checkbox"/> Facial fullness/drooping | <input type="checkbox"/> Uneven skin tone | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Diet/Exercise resistant fat | <input type="checkbox"/> Drooping eyelids | <input type="checkbox"/> Vaginal rejuvenation |
| <input type="checkbox"/> Unwanted hair | <input type="checkbox"/> Drooping brow | <input type="checkbox"/> Adult Acne |
| <input type="checkbox"/> Texture of skin/pore size | <input type="checkbox"/> Double Chin | <input type="checkbox"/> Scar revision |

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

| | | | | |
|---------------------|---|-----------------|---|-------------------|
| <i>Younger Than</i> | | <i>True Age</i> | | <i>Older Than</i> |
| 1 | 2 | 3 | 4 | 5 |

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles, moderate to deep lines or other cosmetic issues.

| | | | | |
|----------------------|---|---------------------------|---|-----------------------|
| <i>Not Concerned</i> | | <i>Somewhat Concerned</i> | | <i>Very Concerned</i> |
| 1 | 2 | 3 | 4 | 5 |

If you are a new client how did you hear about us?

| | |
|--|--|
| <input type="checkbox"/> Radio | <input type="checkbox"/> Referral (who may we thank) |
| <input type="checkbox"/> Internet (google, bing, etc.) | Name: |
| <input type="checkbox"/> Facebook | |
| <input type="checkbox"/> Yelp | Best way to contact: |
| <input type="checkbox"/> Realself | e-mail address |
| <input type="checkbox"/> Magazine | Cell Phone |
| <input type="checkbox"/> Drive by/walk in | |
| <input type="checkbox"/> Other | |

| | |
|--|---|
| <input type="checkbox"/> Are you interested in educational party? (You and 5-15 friends, special pricing, appetizers, wine) | <input type="checkbox"/> Approval to use before and after photos for education or advertising |
| <input type="checkbox"/> Approval to send you information on products and services (including special offers) | <input type="checkbox"/> I am not interested in any additional services at this time |

↓ **For Staff Use Only** ↓

| | | |
|--|-------------|----------------------------|
| Provider: | | |
| <i>Follow-up</i> | <i>Date</i> | <i>Completed by (name)</i> |
| <input type="checkbox"/> Initial Inquiry/Information Given | | |
| <input type="checkbox"/> Contact in future – give date | | |
| <input type="checkbox"/> Products | | |
| <input type="checkbox"/> Free consultation | | |
| <input type="checkbox"/> Procedure scheduled | | |
| <input type="checkbox"/> Procedure completed | | |

Comments: _____