SELF ASSESSMENT - BODY

DATE: ____________________

FULL NAME: ____ **DATE OF BIRTH:** ____________________

WHAT BRINGS YOU IN TODAY? ____

PLEASE CHECK WHAT CONCERNS YOU HAVE:

CONCERNS

- ☐ Excess Fat/Fullness
- ☐ Excess/Loose/Saggy Skin
- ☐ Lack of Muscle Tone
- ☐ Lack of Contour/Definition
- ☐ Volume Loss
- ☐ Stretch Marks
- ☐ Cellulite
- ☐ Unwanted Hair
- ☐ Skin Texture
- ☐ Age/Sun/Brown Spots
- ☐ Excessive Sweating

List Any Other Concern(s) or Issue(s) Below:

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PLEASE CIRCLE OR MARK THE AREAS OF CONCERN:

By sharing how you see yourself, we can best evaluate your goals and help you select appropriate procedures for optimal results.