

## MY CONSULTATION GOALS

Name: \_\_\_\_\_

Date: \_\_\_\_\_

ID Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

How did you hear about us?: \_\_\_\_\_

- 1) Please list the top 3 problems on your “Hit List” that you would like to see improved after surgery (you may list fewer)

### FACE

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

### BODY

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

- 2) Please list the next 3 concerns (if applicable) you would want to address during your consultation:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**3) What adjective(s) best describe your face or body now?**

*For example : **FACE:** rested, youthful, fresh OR tired, angry, sad, droopy, wrinkly*

***Body:** tight, firm, balanced OR droopy, saggy, loose, disproportionate*

**FACE:** \_\_\_\_\_

**BODY:** \_\_\_\_\_

**4) GOALS : What is it you need to see when you look in the mirror in order to be happy after surgery?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5) If you have surgery, how much downtime and/or time off work can you devote to your recovery?**

\_\_\_\_\_ week(s)

**6) If you are considering surgery, would you have help during your recovery? If no, would you wish to arrange for in home assistance?**

\_\_\_\_\_

**7) What non-surgical skin concerns bother you? (Please circle those that apply)**

Wrinkles

Pores

Texture

Brown Pigmentation

Dark Circles

Cellulite

Red Vessels

Other: \_\_\_\_\_

**8) What non-surgical treatments have you had? (Please circle those that apply)**

Botox

Filler (Restylane/Juvederm ect)

IPL/Laser Fotofacial

Laser Hair Removal

Cellulite Treatments

Thermage/ Laser Tightening

Fraxel/Laser Resurfacing

Other: \_\_\_\_\_

\_\_\_\_\_  
**Patient's Name (Please print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**SpaMedica Consultant's / MD Signature**