AESTHETIC GOALS QUESTIONNAIRE

Client Name ____Date_____________________

Address ____

City _____________________________________State_______________Zip Code _____________________________

Preferred Contact Number ___________________ Preferred Email Address ________________________________

Please let us know the primary concern that brought you into our office today: _________________________________

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Please answer the following questions using the scales provided as honestly as possible.

How concerning is the appearance of your wrinkles as you look in the mirror?

Not Concerning Somewhat Concerning Very Concerning

• 1 ------------------- 2 ------------------- 3 ------------------- 4 -------------------- 5 ------------------- 6 -------------------- 7 •

I believe that I look younger, the same as, or older than my age.

Younger Than True Age Older Than

• 1 ------------------- 2 ------------------- 3 ------------------- 4 -------------------- 5 ------------------- 6 -------------------- 7 •

What are your preferred methods of contact (mark all that apply)?

O Cell O Home Phone O Text Message O Email

How did you hear about us?

- **A friend or family member (Name)? ____**
- **Internet? Website Name? ____**
- **Event? Which one? ____**
- **Magazine, Radio or Newspaper? Name? ____**
- **Facebook/Instagram/Social Media**
- **ENT Patient**

What treatments or concerns are you interested in learning more about during your visit today? Use the extra space to elaborate if you wish.

	BOTOX/Dysport		Eye Lid Rejuvenation/Lift
	Dermal Fillers		Brow/Forehead Lift
	Laser Hair Removal		Facelift
	Age Spots		Double Chin Treatments
	Sun Damage		SculpSure Body Contouring
	Facial Redness		SmartLipo Laser Liposuction
	Medical Grade Skin Care		Nose Reshaping
	Looking Tired		Latisse Eyelash Enhancement
	Fine Lines/Wrinkles		Excessive Underarm Sweating
	Broken Capillaries		Spider veins
	Acne or Scarring		Radiofrequency Micro-Needling Skin Rejuvenation
	Fat Transfers		Oily skin
	Lines around the eyes or forehead		Wrinkled Neck/Neck Lift
	Thin Lips		Unwanted Body Fat
	Dry Skin		Dull Skin Appearance
	Red and Brown Spots		Lines Around the Mouth
	Micro-Dermabrasion		Other:

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Patient Signature **Printed Name**

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Date