

Share how you see yourself

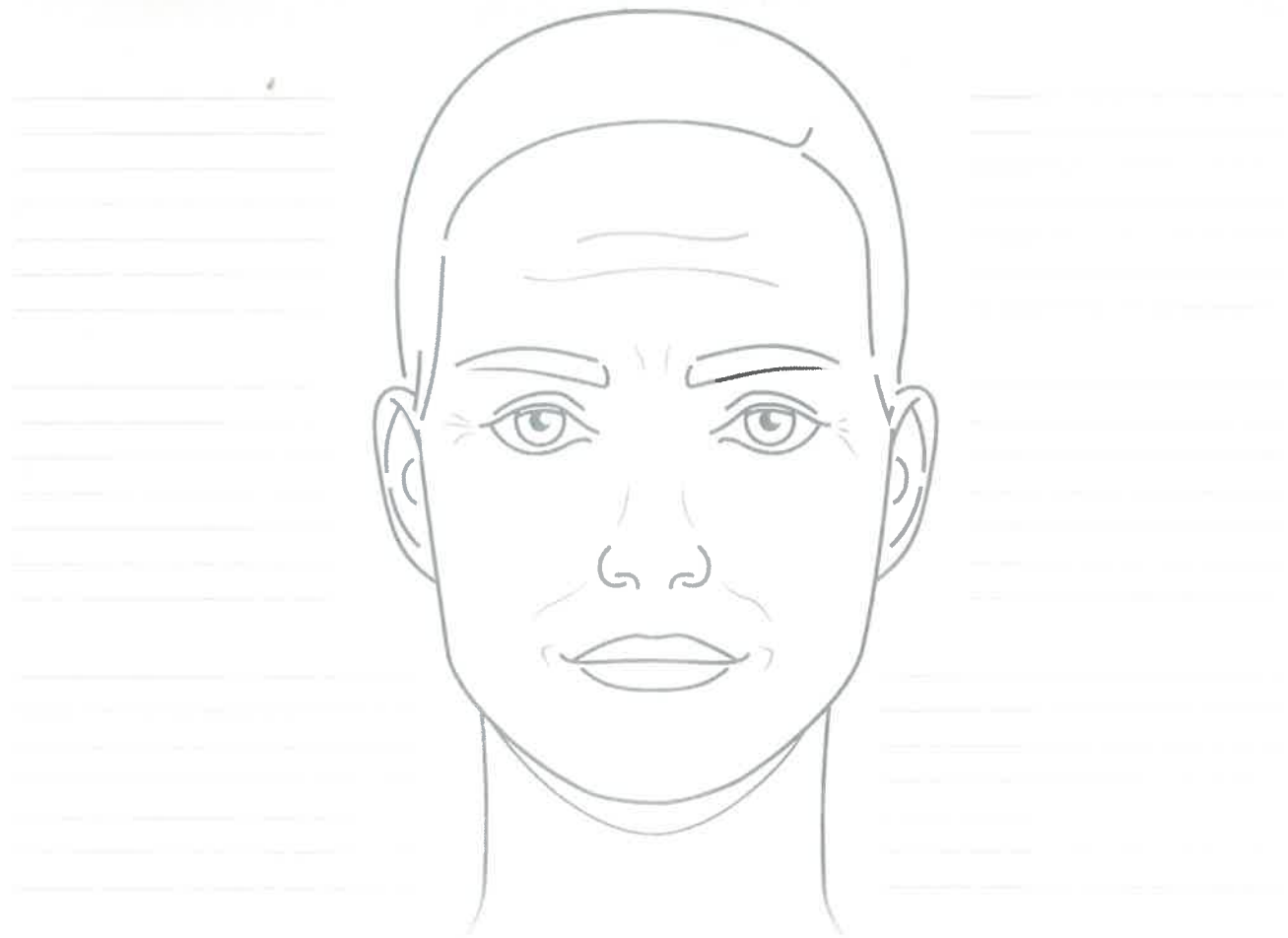
**I feel like
 I look:**

Check all that apply.

- | | | | |
|--------------------------------|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Sad | <input type="checkbox"/> Less lively | <input type="checkbox"/> Pained | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Fearful | <input type="checkbox"/> Less desirable | _____ |
| <input type="checkbox"/> Tired | <input type="checkbox"/> Saggy | <input type="checkbox"/> Older than I feel | _____ |

FOR USE WITH YOUR AESTHETIC PROVIDER

Evaluate concerns and aesthetic goals to customize each consultation



Patient name:

Next appointment date: / /