Ohio Valley Surgical Arts
Cosmetic + Laser Center

MY CONSULTATION GOALS

Name:_____ Date: _____

Date of Birth:_____

How did you hear about us? _____

1) Please list the top 3 concerns you want to address during your consultation:

1) _____

2) _____

3) _____

2) What adjective(s) best describe your appearance now?

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

_____

_____

3) How many years younger / fresher would you like to look? (Please circle that which applies)

0-5 years 6-10 years 11-15 years >15 years

4) How much money do you want to spend to achieve your goals? (Please circle that which applies)

0- $5000 $6000 - $10,000 $11,000 - $15,000 $16,000 - $20,000

5) How much time off can you devote to your enhancement? (Please circle that which applies)

0-1 weeks 1-3 weeks > 3 weeks

6) Do you want surgical or Non-Surgical treatment options? (Please circle that which applies)

Surgical Non-Surgical

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

_____

_____

8) What skin concerns do you have? (Please circle those that apply)

Wrinkles	Pores	Texture	Brown Pigmentation
Dark Circles	Red Vessels	Other: _____	

9) What treatments/procedures have you had? (Please circle those that apply)

Botox	Filler (Radiesse/Restylane/Juvederm etc)	IPL/Laser Fotofacial
Laser Hair Removal	Cellulite Treatments	Thermage/ Laser Tightening
Fraxel/Laser Resurfacing	Chemical Peel	Blepharoplasty
Rhinoplasty	Facelift	Cool Sculpting
Ultheraphy		

Other: _____

10) What treatments/procedures would you be interested in having?

_____

_____ _____

Patient Name (please print) **Date**

_____ _____

Patient Signature **Physician Signature**