Kairos Beauty

Enhance Beauty Erase Time

PATIENT INTEREST INTAKE FORM

Name DOB Date

Please indicate any areas of concern. Check all that apply.

- ☐ Forehead Lines
- ☐ Frown Lines
- ☐ Crow's feet lines
- ☐ Undereye area
- ☐ Flattened/sunken cheeks
- ☐ Nasolabial Folds/Marionette Lines
- ☐ Lines and wrinkles around nose and mouth
- ☐ Nasolabial Folds/Marionette Lines
- ☐ Lines and wrinkles around nose/mouth
- ☐ Thin Lips
- ☐ Double Chin
- ☐ Small chin, weak chin profile
- ☐ Skin texture/appearance
- ☐ Other: ______________________________

How do you see yourself? Check all that apply.

- ☐ I feel I look tired
- ☐ I feel I look sad
- ☐ I feel I look mad
- ☐ I feel I have saggy skin
- ☐ I look older than I am
- ☐ I don't look contoured
- ☐ I don't look or feel smooth
- ☐ Other: ______________________________

If there is anything else you would like to discuss during your consultation, please indicate it below.

____

____

____

____