

PERSONAL TREATMENT PLAN

Name: _____ Date: _____

Skin sensitivities and allergies: _____

These are the areas of concern
for me:

Fine lines and wrinkles

Major lines around nose
and mouth

Rough texture of skin

Tired or Dull looking skin

Lips not full enough

Skin sagging or lacking
fullness

Unwanted hair

Hyperpigmentation /
Brown Spots

Bags under eyes

Acne

Blackheads/Whiteheads

Acne scars / Scars

Dark circles under eyes

Freckles

Dryness

Redness of Face/broken
capillaries

Large visible pores

Uneven skin tone

Are you using or have you used Accutane? Yes No If yes: how long ago? _____

Are you susceptible to cold sores? Yes No

Do you smoke? Yes No

Do you experience ingrown hairs? Yes No

Do you use a sunscreen/sunblock? Yes No

Does your skin have dry patches? never occasionally frequently

Ranking of Concerns:

1.: _____

2.: _____

3.: _____

4.: _____