the saltFACIAL®
THE SCIENCE YOUR SKIN NEEDS.

Treatment Form

NAME: _____ DOB: _____ AGE: _____ TX DATE: _____

PATIENT ID: _____

SKIN CONDITION/CONCERNS:

REJUVENATION ***PIGMENTATION*** ***ACNE*** ***OTHER***

PRE-TREATMENT PHOTO: YES ☐ NO ☐

TREATMENT PLAN SERIES: YES ☐ NO ☐ NUMBER OF TXS: _____

CURRENT NUMBER IN SERIES: _____

TREATMENT DETAILS:

Step 1: SaltFacial Setting: 3 4 5 6 7 8 9 10

Step 2: Ultrasound Massage Topical DermMasque Used:

GLYCOLIC ☐ MANDELIC ☐ GLIDING GEL ☐

Step 3: LED Phototherapy Mode: ACNE LIGHT THERAPY ☐ BLUELIGHT ☐

COLLAGEN RESTORATION ☐ SKIN REJUVENATION ☐

the saltFACIAL®
THE SCIENCE YOUR SKIN NEEDS.

Treatment Assessment:

FOLLOW UP INSTRUCTIONS:

POST TREATMENT PHOTO: YES ☐ NO ☐

OTHER INSTRUCTIONS:

FOLLOW - UP DATE:

PATIENT NAME: _____

PATIENT SIGNATURE: _____

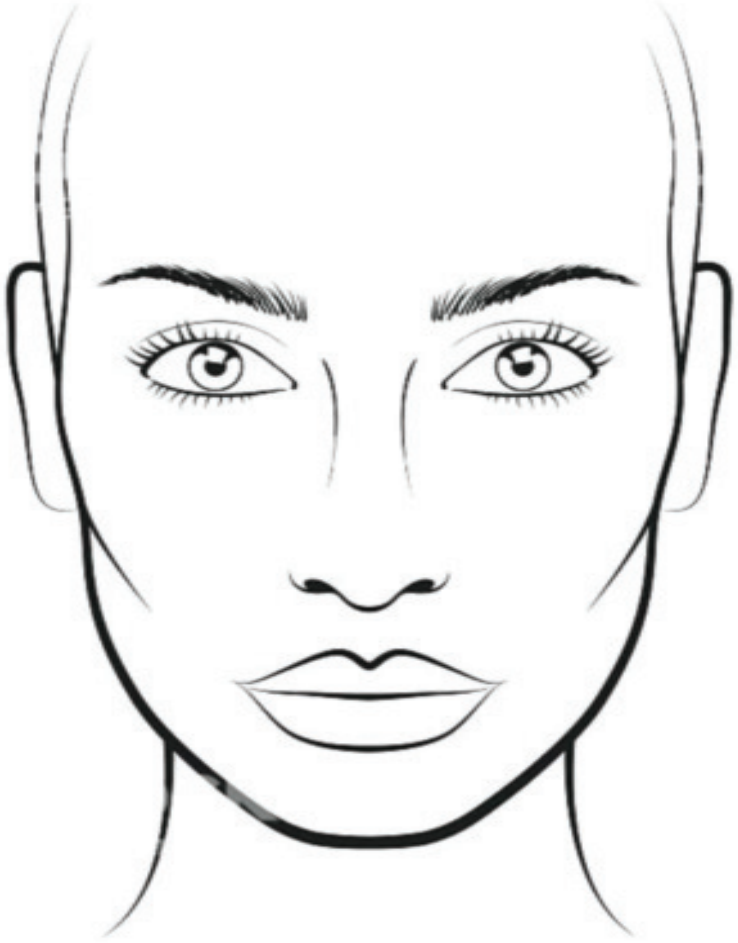
DATE: _____

the saltFACIAL®

THE SCIENCE YOUR SKIN NEEDS.

PATIENTS NAME: _____

PROVIDER: _____ DATE: _____



FOREHEAD _____	**UPPER EYELIDS** _____
CHEEKS _____	**LOWER EYELODS** _____
NOSE _____	**CROW'S FEET** _____
PERIORAL _____	**SUBMENTUM** _____
UPPER LIP _____	**NECK** _____