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THE SCIENCE YOUR SKIN NEEDS.

Treatment Form

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

PATIENT ID: _____

SKIN CONDITION/CONCERNS: _____

_____

_____

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 Topical Used:

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

COLLAGEN RESTORATION ☐ SKIN REJUVENATION ☐

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Treatment Assessment:

FOLLOW UP INSTRUCTIONS:

POST TREATMENT PHOTO: YES ☐ NO ☐

OTHER INSTRUCTIONS:

FOLLOW - UP DATE:

PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____

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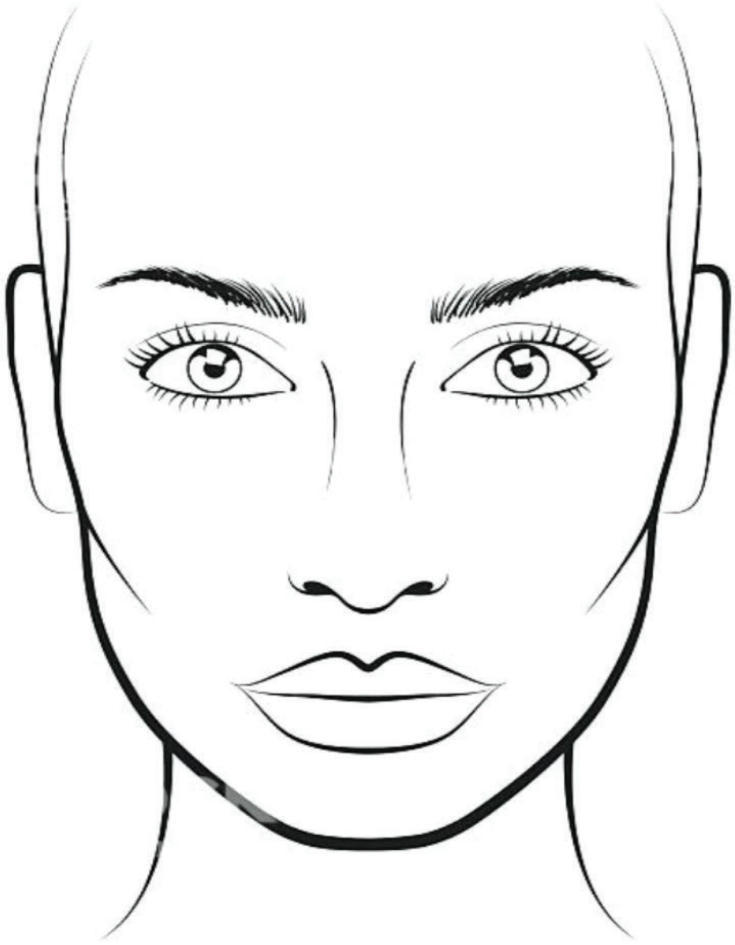
PATIENTS NAME: _____

PROVIDER: _____ DATE: _____



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