

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 ☐

Treatment Assessment:

FOLLOW UP INSTRUCTIONS:

POST TREATMENT PHOTO: YES ☐ NO ☐

OTHER INSTRUCTIONS:

FOLLOW - UP DATE:

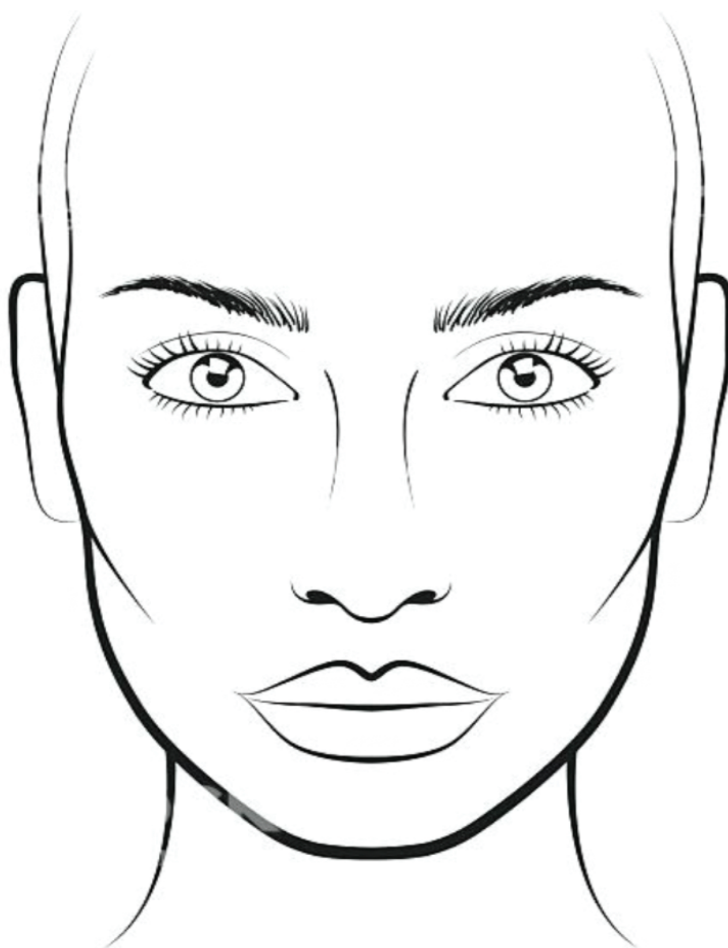
PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____

PATIENTS NAME: _____

PROVIDER: _____ DATE: _____



FOREHEAD _____

CHEEKS _____

NOSE _____

PERIORAL _____

UPPER LIP _____

UPPER EYELIDS _____

LOWER EYELODS _____

CROW'S FEET _____

SUBMENTUM _____

NECK _____