

Client Information

Client Name: _____

Original Procedure Date: _____

Client ID:

Original Model:

Touch-Up Sessions

Healing Assessment

Color retention:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Skin response:	<input type="checkbox"/> Normal	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Oily migration	<input type="checkbox"/> Scarring
Shape integrity:	<input type="checkbox"/> Maintained	<input type="checkbox"/> Minor fading	<input type="checkbox"/> Needs adjustment	<input type="checkbox"/> Significant change
Client satisfaction:	<input type="checkbox"/> Very satisfied	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Needs improvement	<input type="checkbox"/> Unsatisfied

Recommendations for Next Session

Next touch-up recommended:

Scheduled date: