

# Progressive Treatment Record



**Date:** \_\_\_\_\_ **Skin Care Professional:** \_\_\_\_\_

Specific Concerns: \_\_\_\_\_

Type of treatment: \_\_\_\_\_

Notes/Remarks: \_\_\_\_\_

Recommended Home Skin Care Products:

For Daytime:

For Nighttime:

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\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_

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