HAIR LOSS SOLUTIONS | STOP REGROW CONCEAL

CONFIDENTIAL CONSULTATION QUESTIONNAIRE

Name: _____Date: _____

Address: _____

City: _____State_____Zip_____

Home Phone:_____ Work phone:_____

DOB_____ Age_____

Occupation_____

E-mail Address_____

Referred by: ☐ TV AD ☐ Internet ☐ Facebook ☐ Radio

Salon_____ Other_____

Personal History:

Allergies_____ Are you allergic to shellfish?_____

General Health_____

Previous Surgery with General Anesthesia_____

Do you have any of the following issues?

☐Stroke ☐Congestive Heart Failure ☐ Irregular Heart Beat ☐ Hypertension (High Blood Pressure)

☐Coronary Artery Disease ☐Anemia ☐ Depression ☐Thyroid Disease

☐ Endocrine Disorders ☐ Diabetes ☐ Liver Disease ☐ Rosacea

Presently undergoing treatment for_____

Physician's name: _____Date of last physical:_____

Stress: ☐High ☐Medium ☐Low

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Medications: Please list name of medication and dosage

Anti-coagulants_____ Anti-hypertensive_____

Hormones_____ Thyroid_____ Aspirin_____ Multivitamins_____

Radiation Therapy_____ Chemotherapy_____

Taking any medication or supplements? Please List_____

_____

Females Only

Female issues: ☐ Yes ☐No Post Menopausal: ☐Yes / ☐No

Are you planning to get pregnant in the next 6 months? ☐ Yes / ☐No

Are you currently pregnant or nursing? ☐ Yes / ☐No

Do you take Contraceptive Pills? ☐Yes /☐ No

How long have you taken them:_____

Males Only

Have you currently had or plan to take a PSA blood test for the screening of prostate cancer?

☐ Yes ☐No

Do you have an enlarged prostate, prostate cancer? ☐Yes ☐ No

Nutrition:

Are you a vegetarian? ☐ Yes / ☐ No

How many daily servings of protein?_____

Fruit_____ Vegetables_____ Caffeine_____

Carbohydrates_____ Protein_____ Lost weight recently?_____

How much?_____

HAIR & SCALP Condition(s)

Is your Scalp: ☐Dry ☐ Oily ☐ Normal ☐Dandruff

Any Redness or itchy scalp: ☐ Yes ☐ No **Do you pull your hair?**☐ Yes ☐ No

Any Bumps or raised areas: ☐ Yes ☐ No

Recurrent attacks of patchy loss: ☐ Yes ☐ No **Hair of different lengths** ☐Yes ☐ No

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Areas of hair loss: ☐All over scalp ☐ Front ☐Crown

Any loss of hair on body? ☐Yes ☐ No What area? _____

At what age did you notice hair loss?_____ **☐Sudden / ☐Gradual**

Is your hair loss getting worse_____ **How many hairs lost per day?** _____

What kind of shampoo do you use? _____ **Conditioner**?_____

How many times per week do you shampoo? _____

Do you use a hair dryer? ☐ Yes ☐ No **What temperature?** ☐ Hot ☐ Medium ☐Cool

When hair is wet, do you use a towel to rub dry? ☐Yes ☐ No

Do you color your hair? ☐ Yes☐ No **How often?**_____

Is your hair loss concern caused by any medical problems or medications that you are aware of?_____

HEREDITY Does hair loss run in your family? ☐Yes ☐ No

	BALD	THINNING HAIR	NOT BALD	UNKNOWN
Parents				
Grandparents				
Siblings				
Aunt				
Uncle				

What options have you researched for your hair loss (Including over the counter and prescriptions)?

☐Transplants ☐Scalp Treatments ☐Hair Replacement or weaves

☐Over the counter products ☐ Prescription products ☐Avacor

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Minoxidil_____% Other _____ Clubs or Hair Loss Clinics_____

How much does your hair loss bother you? ☐Slightly ☐ Moderately ☐ Highly

Did you tell anyone that you were coming here today? ☐Yes ☐No

What are your goals and expectations?

☐Prevent further loss ☐Gain back hair quickly

☐Gradually gain back some hair ☐Other _____

Knowing that treatment and/or surgical options may take 6 months or more to show success, are you willing to wait that long? ☐ Yes ☐ No

Please indicate where hair loss bothers you the most.

☐	No variation in hair style	☐	Seeing pictures/videos
☐	Going outside on windy days	☐	Wearing hats when going out
☐	Social Life	☐	Swimming or getting caught in the rain
☐	Seeing old friends	☐	Overall self esteem
☐	Participating in sports	☐	Meeting new people
☐	Overall appearance	☐	People make comments
☐	Conscious of appearance at work	☐	Other:_____

Consent for treatment

I agree to being evaluated and I understand I will first undergo a comprehensive preliminary evaluation by an experienced consultant. All other checkups are included with the cost of the program, which include monthly and/or quarterly digital and microscopic pictures, for which I give my consent. I further understand results will vary depending on a large number of factors. I acknowledge that it is my responsibility to the company of any changes in my condition, no matter how slight.

I understand some general recommendations will be made based on the initial consultation.

SIGNATURE:_____ DATE:_____