



salon & training institute

eastgate towne center | 5600 brainerd road, ste. b8 chattanooga, tn 37411 | salon: 423.510.0883 | mobile: 423.593.4146

CONFIDENTIAL CONSULTATION QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_

DOB \_\_\_\_\_ Age: \_\_\_\_\_ Occupation \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Referred by: TV AD Internet Yellow Pages Google

Salon Name: \_\_\_\_\_ Other \_\_\_\_\_

MEDICAL HISTORY

Allergies: \_\_\_\_\_ Are you allergic to shellfish? \_\_\_\_\_

General Health \_\_\_\_\_

Previous Surgery with General Anesthesia \_\_\_\_\_

Do you have any of the following medical problems?

- Stroke Congestive Heart Failure Irregular Heart Beat Hypertension
Coronary Artery Disease Anemia Depression Thyroid Disease
Endocrine Disorders Diabetes Liver Disease Resaca

Presently Undergoing Medical Treatment for \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Date of last physical \_\_\_\_\_

Stress: High \_\_\_\_\_ Medium \_\_\_\_\_ Low \_\_\_\_\_

Blood work: Have you had any of these tests done in the past year?

- CBC w/Diff Ferritin/Iron test Thyroid Panel Glucose Tolerance

Hormone: DHEA/Testosterone



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### Condition of Hair and Scalp

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 hair loss:    Yes    No    Hair of different lengths    Yes    No

Areas of hair loss:    All over scalp            Front                    Crown

Any hair loss on body?    Yes    No    What area? \_\_\_\_\_

At what age did you notice hair loss? \_\_\_\_\_ Was loss sudden? \_\_\_\_\_ or Gradual? \_\_\_\_\_

Is your hair loss getting worse? \_\_\_\_\_ If yes, can you collect in plastic bag daily? \_\_\_\_\_

What kind of shampoo do you use? \_\_\_\_\_ Conditioner? \_\_\_\_\_ Co-Wash? \_\_\_\_\_

How many times per week do you shampoo? \_\_\_\_\_

What type of hair dryer do you use? \_\_\_\_\_ What temperature?    Hot    Medium    Cool

Do you towel dry your hair when wet?    Yes    No

Is your hair color treated?    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				
Grand P				
Siblings				
Aunt				
Uncles				



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

Transplants    Scalp Treatments    Hair Replacements or weaves

Over the counter products    Prescription products    Avacor    Minoxidil \_\_\_\_\_%

Other \_\_\_\_\_    Clubs or Hair Loss Clinics \_\_\_\_\_

**Medications:** Please list name of medication and dosage

Anti-coagulants \_\_\_\_\_ Anti-Hypertensive \_\_\_\_\_

Hormones \_\_\_\_\_ Thyroid \_\_\_\_\_ -Asprin \_\_\_\_\_ Multivitamins \_\_\_\_\_

Radiation Therapy \_\_\_\_\_ Chemotherapy \_\_\_\_\_ Dialysis \_\_\_\_\_

List any other medications \_\_\_\_\_

### **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 any type of Contraceptive? Yes    No    How long? \_\_\_\_\_

Name \_\_\_\_\_

### **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 or prostate cancer? Yes    No



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### **Nutrition:**

Are you a vegetarian? Yes No How many servings of protein do you get daily? \_\_\_\_\_

Fruit \_\_\_\_\_ Veggies \_\_\_\_\_ Caffeine \_\_\_\_\_ Carbs \_\_\_\_\_ Protein \_\_\_\_\_

Do you take minerals in any form? Yes No Multi-Vitamins Yes No

Lost or gained weight recently? Yes No How much? \_\_\_\_\_

List any other supplements that you take \_\_\_\_\_.

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

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

Would you consider using prescription topical and pills if you could get better results? (Keep in mind, prescription products in general increase the cost of the program). Yes \_\_\_\_\_ No \_\_\_\_\_

### **What are your goals and expectations?**

To prevent further loss \_\_\_\_\_ Get hair back quickly \_\_\_\_\_

Gradually gain back some hair \_\_\_\_\_ Other \_\_\_\_\_

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

Please circle where hair loss bothers you the most?

No variation in hair style      Seeing old 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

Conscious of appearance at work      Comments that people make      Around your mate

