



## Hair Consultation Intake Form

### Patient Information:

Full Name: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_

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

Contact Number: \_\_\_\_\_

### Reason for Visit:

- Are you interested in hair restoration? ☐ Yes ☐ No
- What are your primary concerns related to your hair or scalp? \_\_\_\_\_

### Medical History:

- Have you ever been diagnosed with or experienced any of the following conditions?
  - Androgenic Alopecia: ☐ Yes ☐ No
  - Telogen Effluvium: ☐ Yes ☐ No
  - Alopecia Areata: ☐ Yes ☐ No
  - Frontal Fibrosing: ☐ Yes ☐ No
  - Trichotillomania: ☐ Yes ☐ No
  - Scarring Alopecia: ☐ Yes ☐ No
  - Lichen Planopilaris: ☐ Yes ☐ No
  - Alopecia Totalis: ☐ Yes ☐ No
- Do you have any other medical conditions related to the hair or scalp (e.g., seborrheic dermatitis, psoriasis)?
  - If yes, please specify: \_\_\_\_\_
- Are you currently taking any medications, including supplements?
  - If yes, please list: \_\_\_\_\_
- Have you experienced any recent changes in health (e.g., hormonal changes, stress, weight changes)?
  - If yes, please explain: \_\_\_\_\_
- Family History: Does anyone in your family experience hair thinning or loss?
  - If yes, please specify: \_\_\_\_\_



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### Hair Care Routine:

- How often do you wash your hair? \_\_\_\_\_
- What products do you use on your hair and scalp? \_\_\_\_\_
- Do you use any hair treatments (e.g., coloring, keratin, heat styling)?
  - If yes, please specify: \_\_\_\_\_

### Lifestyle Factors:

- Are you experiencing increased stress levels? \_\_\_\_\_
- Do you follow any specific diet or have dietary restrictions?
  - If yes, please specify: \_\_\_\_\_
- Do you smoke or use recreational drugs? \_\_\_\_\_
- How often do you exercise? \_\_\_\_\_

### Previous Treatments & Results:

- Have you tried any previous treatments for hair or scalp concerns?
  - If yes, what treatments and results? \_\_\_\_\_

### Consent & Acknowledgement:

- I hereby consent to the collection and use of my personal and medical information for the purpose of hair consultation and treatment. I understand that my data will be kept confidential in accordance with data protection regulations.
  - Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
To be filled out by the office

### Provider Notes:

- Initial Observations: \_\_\_\_\_
- Recommended Treatments/Next Steps: \_\_\_\_\_
- Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_