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Confidential Consultation Questionnaire

Name: _____Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work phone: _____

DOB: _____ Age: _____ Occupation: _____

E-mail Address: _____

Referred by: ○ **Doctor** ○ **Google Search** ○ **Facebook** ○ **Instagram** ○ **TikTok** ○ **Internet**

○ **Social Media** ○ **TV** ○ **Radio**

Salon: _____ Other: _____

If other who referred, you? _____

Personal History:

Allergies: _____ Are you allergic to shellfish? ○ Yes ○ No

General Health: _____

Previous Surgery with General Anesthesia: _____

Do you have any of the following issues?

○ **Stroke** ○ **Congestive Heart Failure** ○ **Irregular Heartbeat** ○ **Hypertension Coronary Artery Disease**

○ **Anemia** ○ **Depression** ○ **Thyroid Disease** ○ **Endocrine Disorders**

○ **Diabetes** ○ **Liver Disease** ○ **Rosacea**

Presently undergoing treatment for: _____

Physician's name: _____ Date of last physical: _____

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Stress: ○ **High** ○ **Medium** ○ **Low**

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Medications:

Please list the name(s) of medication(s) and dosage(s) if applied.

Anti-coagulants: _____ Anti-hypertensive: _____

Hormones: _____ Thyroid: _____ Aspirin: _____ Multivitamins: _____

Radiation Therapy: _____ Chemotherapy: _____

Taking any medication or supplements? Please List: _____

_____

Females Only

Female issues: ○ **Yes** ○ **No** Postmenopausal: ○ **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? ○ **Yes** ○ **No**

How much? _____

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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** 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?

_____

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Heredity:

Does hair loss run in your family? Insert ○ Yes ○ No in the chart below.

	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)?

○ Growth Factors ○ Low-Level Laser Therapy ○ Platelet-rich plasma ○ Rogaine / Minoxidil 5%

○ Finasteride / Propecia ○ Laser Cap ○ Microneedling ○ Transplants ○ Hair Replacement / Wigs

○ SMP ○ XTC ○ HLCC ○ Bosley ○ Hair Club ○ Keeps ○ Hims / Hers ○ Nutrafol ○ Keranique

○ Other _____ ○ Other _____ ○ Other _____

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**

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Please indicate where hair loss bothers you the most.

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

Consent for treatment

I agree to be evaluated and I understand I will first undergo a comprehensive preliminary evaluation by an experienced consultant. All other checkups are included with the program's cost, which includes 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 for any changes in my condition, no matter how slight.

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

SIGNATURE: _____ DATE: _____