Hair and Scalp Client History Form

Name: _____

Date: _____

1. HOW WOULD YOU DESCRIBE YOUR CURRENT HAIR TYPE?

1. Oily
2. Normal
3. Dry
4. Combination (Oily scalp, Dry ends)

2. ARE YOU CURRENTLY EXPERIENCING ANY SPECIFIC SCALP ISSUES?

1. Excess oiliness
2. Dryness and Flakiness
3. Itchiness
4. Other (please specify) _____

3. HOW OFTEN FO YOU WASH YOUR HAR IN A WEEK?

1. Daily
2. Every other day
3. 2-3 times a week
4. Once a week or less

4. HAVE YOU RECENTLY UNDERGONE CHEMICAL HAIR TREATMENTS (COLORING, PERMING, ETC.)?

1. Yes
2. No

5. DO YOU EXPERIENCE ANY TENDERNESS OR DISCOMFORT WHEN TOUCHING YOUR SCALP?

1. Yes
2. No

6. ON A SCALE OF 1–10, HOW WOULD YOU RATE YOUR OVERALL SCALP COMFORT?

1 2 3 4 5 6 7 8 9 10

7. HOW WOULD YOU DESCRIBE YOUR STRESS LEVELS REGULARY?

1. Low
2. Moderate
3. High

8. DO YOU WORK OR LIVE IN AN ENVIRONMENT WITH SIGNIFICANT POLLUTION OR HARSH WEATHER CONDITIONS?

1. Yes
2. No

9. WHAT TYPE OF HAIR CARE PRODUCTS DO YOU REGULARLY USE?

1. Sulfate-free
2. Moisturizing
3. Clarifying
4. Other (please specify) _____

10. HOW FREQUENLTY DO YOU USE STYLING PRODUCTS (HAIRSPRAY, GEL, ATC.)?

1. Daily
2. Occasionally
3. Rarely
4. Never

11. DO YOU HAVE ANY KNOWN ALLERGIES OR SENSITIVITIES TO HAIR CARE INGREDIENTS?

1. Yes
2. No

12. DO YOU HOPE TO ACHIEVE ANY SPECIFIC OUTCOMES WITH THE SCALP MASSAGE TREATMENT?

1. Improved scalp health
2. Reduced oiliness
3. Relief from dryness ad itching
4. Other (please specify) _____

Client Signature: _____

By signing above, I confirm that the information provided is accurate to the best of my knowledge.