HAIRCOACH CONSULT INTAKE FORM

The information you provide below will be used to help create your hair plan. Answers are confidential.

Today's Date:	Hair Coach Name:
Name:	Referred by:
Age:	Cell Phone:
Date of Birth:	Evening Phone:
Home Address:	Preferred method of contact:
City: State: Zip:	Occupation:
Marital Status: ☐Single ☐Married ☐Div ☐Widowed	Emergency Contact Person:
Email: ☐Yes send me updates	Emergency Contact Phone:

1. How would you characterize your current degree of hair loss? ☐ Minimal ☐ Mild/Moderate ☐ Extensive

2. What is your main area of concern? ☐ Hairline/Temples ☐ Frontal area ☐ Crown (top) ☐ All ☐ Other:

3. I'm experiencing: ☐ Thinning ☐ Receding ☐ Shedding ☐ Breakag ☐ Oily Scalp ☐ Itchy/Dry/Flaking scalp

4. Is your hair loss: ☐ Just starting ☐ Accelerating ☐ Slowing down ☐ Basically done ☐ Not sure

5. Hair loss affects me: ☐ When getting dressed in the morning ☐ When meeting new people ☐ Seeing old friends ☐ On windy days ☐ Whenever I wear a hat ☐ When swimming ☐ At formal events ☐ When people make comments ☐ When I see videos or pictures of myself ☐ In my overall social life ☐ My overall self-esteem ☐ At work or school

6. Do you regularly use any form of scalp camouflage (powder, makeup, spray, Toppik) ☐ Yes ☐ No

7. Tried any of the following to prevent hair loss? (check all that apply) ☐ Propecia/Proscar ☐ Rogaine/Minoxidil ☐ Avodart/Dutasteride ☐ LaserComb ☐ Laser Therapy Hood ☐ Vitmns/Supplmnts-which? _____ ☐ Special Shampoo-which? _____ ☐ Hair Transplant Surgery ☐ Other:_____ ☐ None of the above

8. Are you currently taking Propecia or Proscar? ☐ Yes ☐ No If Yes, approximate date when you started? _____
   - Do you feel it has been effective? ☐ Yes ☐ No ☐ Unsure

9. Are you currently using Rogaine or Minoxidil? ☐ Yes ☐ No If Yes, approximate date when you started? _____
   - ☐ 2% or ☐ 5%? How often? _____ Do you feel it has been effective? ☐ Yes ☐ No ☐ Unsure

10. What brand of shampoo and conditioner do you use most often?

11. When did you first begin to notice your hair loss?

Please identify any specific areas of interest (check all that apply):

☐ Propecia ☐ Rogaine/Minoxidil ☐ Hair Transplantation ☐ Hair Care Products ☐ Laser Therapy ☐ Camouflage ☐ Nutritional Supplementation ☐ Eyelashes ☐ Eyebrows ☐ Genetic Hair Loss Test ☐ Other: _____

12. How would you rate the condition of your health? ☐ Excellent ☐ Good ☐ Satisfactory ☐ Fair ☐ Poor

13. How would you rate your current nutritional status? ☐ Excellent ☐ Good ☐ Satisfactory ☐ Fair ☐ Poor

14. Your current stress management skills are: ☐ Excellent ☐ Good ☐ Satisfactory ☐ Fair ☐ Poor

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TYPE	RISK FACTORS	YES	NO
FACTS	Do any of your "blood relatives" have thin hair or hair loss?	☐	☐
	Is your hair part-line widening?	☐	☐
	Is hairline receding or noticed less hair coverage & more scalp showing?	☐	☐
	Have you worn/currently wear a hair piece, hair system, or extensions?	☐	☐
LIFESTYLE	Do you routinely color your hair?	☐	☐
	Do you routinely chemically perm or straighten your hair?	☐	☐
	Do you routinely take a protein shake containing Creatine?	☐	☐
	Do you drink alcoholic beverages?	☐	☐
	Are you a smoker? (or ex-smoker) of cigarettes/cigars?	☐	☐
PRESCRIPTIONS	**Do you/have you taken prescription medication for:**		
	High Blood Pressure?	☐	☐
	Elevated Cholesterol?	☐	☐
	Depression/anxiety?	☐	☐
	Anemia (low iron)?	☐	☐
DIAGNOSIS	**Have you ever been diagnosed with:**		
	Hormone Abnormalities?	☐	☐
	Eating Disorder?	☐	☐
	Menstrual Cycle Abnormality?	☐	☐
	Recent Pregnancy?	☐	☐
	Menopause?	☐	☐

15. Ever had an allergic response or adverse reaction to substances placed on your skin? ☐ Yes ☐ No
If so, please describe:

16. Are you aware of any allergies you might have to any foods, drugs or medications? ☐ Yes ☐ No Which?
☐ Dairy ☐ Fish/Seafood ☐ Other (please list)

17. Have you had a hair restoration consultation in the past? ☐ Yes ☐ No If Yes, where?

18. Have you ever had a genetic test for Hair Loss? ☐ Yes ☐ No If Yes, outcome?

19. Have you ever had a hair transplant? ☐ Yes ☐ No If Yes, by whom?

(THIS TABLE FOR HAIR COACH USE) TAB# ⇨	OCCIPTL	CROWN	FRONT	TEMPLE	HAIRCHECKER NAME_____
INITIAL HMI					% Breakage/Loss: _____
AREA OF CONCERN	☐	☐	☐	☐	☐ Other: _____

NOTES/OBSERVATIONS/NEXT HAIRCHECK SET FOR +90 Days Date:_____/_____/_____ Time: _____PM or AM

7 Photos – wet hair if possible for best results then email to HairCoach@BaumanMedical.com or text to 561.213.2638 to share with Dr. B.

☐ Front: looking straight at the camera, ☐ Front: person is facing forward with head slightly tilted down ☐ Back: hair is parted at the center (vertically, top to bottom) ☐ Top: separate hair to reveal existing coverage ☐ Left Side ☐ Right Side ☐ Plus any particular areas of concern

SIGNATURE & ACKNOWLEDGEMENT: To the best of my knowledge, I answered all of the questions in this form accurately. I understand that this program is not a substitute for medical advice and any medical questions will be directed to a licensed physician.

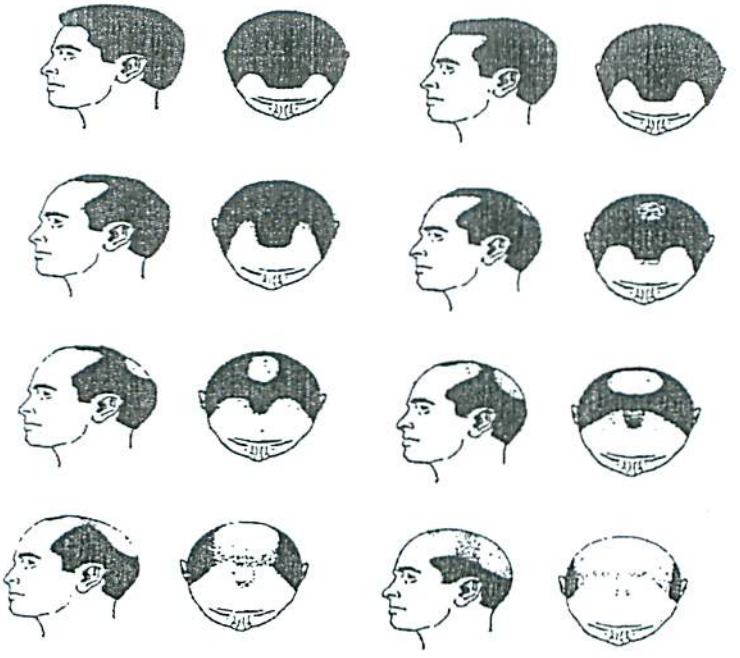
Printed Name:_____ Signature:_____ Date: _____

QUESTIONS? SPEAK WITH YOUR HAIR COACH or CALL 1.561.213.2638 or EMAIL HairCoach@BaumanMedical.com
BRING TO HAIR COACH OR FAX COMPLETED FORM TO 1.561.394.4522 or TEXT PIC TO 1.561.213.2638

Silverado
Medical & Aesthetic Clinic

Client Hair Loss History

Please circle the picture that best represents your hair loss today:



Please circle the picture that best represents your hair loss today: