CONFIDENTIAL CONSULTATION QUESTIONNAIRE

PERSONAL INFORMATION

Name :

Address : City:

State : Zip: Email:

Cell # : Date of Birth

Age : Occupation:

Referred By : ☐ Doctor ☐ Google ☐ Facebook ☐ Instagram ☐ TikTok ☐ Internet

☐ TV ☐ Radio Other

PERSONAL HISTORY

Allergies :

Are you allergic to shellfish? ☐ Yes ☐ No Previous Surgery with General Anesthesia: ☐ Yes ☐ No

General Health :

Do You Have The Following Issues?

☐ Stroke ☐ Stress ☐ Congestive Heart Failure ☐ Irregular Heartbeat

☐ Anemia ☐ Diabetes ☐ Depression ☐ Hypertension Coronary Artery Disease

☐ Rosacea ☐ Thyroid Disease ☐ Liver Disease ☐ Endocrine Disorders

Presently Undergoing Treatment For:

Physician's Name:

Date of Last Physical:

Stress Level ☐ High ☐ Medium ☐ Low

MEDICATIONS

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

Anti-coagulants:

Anti-hypertensive:

Hormones:

Thyroid:

Aspirin:

Multivitamins:

Radiation Therapy: ☐ Yes ☐ No **Chemotherapy:** ☐ Yes ☐ No

Taking any medication or supplements? Please List:

FEMALES ONLY

Suffering From Female issues: ☐ Yes ☐ No

Are You Postmenopausal: ☐ Yes ☐ No

Currently pregnant or nursing? ☐ Yes ☐ No

Do you take Contraceptive Pills? ☐ Yes ☐ No

Plan to get pregnant in the next 6 months? ☐ 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:**

Lost weight recently? ☐ Yes ☐ No **How Much?**

HAIR & SCALP CONDITION(S):

Is your Scalp: ☐ Dry ☐ Oily ☐ Normal ☐ Dandruff

Redness or itchy scalp: ☐ Yes ☐ No Do you pull your hair? ☐ Yes ☐ No

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

Any loss of hair on body? ☐ Yes ☐ No What Area?

What age did you notice hair loss? ☐ Sudden ☐ Gradual

Is your hair loss getting worse? ☐ Yes ☐ No 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?

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				

HAIR & SCALP TREATMENT

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

☐ Growth Factors ☐ Exosomes ☐ Low-Level Laser Therapy ☐ (PRP) Platelet-rich plasma

☐ Rogaine / Minoxidil 5% ☐ Finasteride / Propecia ☐ Microneedling ☐ Laser Cap Device

☐ Hair Transplants ☐ Hair Replacement / Wigs ☐ (SMP) Scalp Micropigmentation

☐ (XTC) Xtreme Total Care ☐ (HLCC) Hair Loss Control Clinic ☐ Bosley ☐ Hair Club ☐ Keeps

☐ Hims/Hers ☐ Nutrafol ☐ Keranique

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

Please indicate where hair loss bothers you the most.

☐ No variation in hairstyle ☐ Seeing pictures/videos ☐ Participating in sports

☐ Going outside on windy days ☐ Wearing hats when going out ☐ Overall appearance

☐ Social Life ☐ Swimming or getting caught in the rain ☐ Conscious of appearance at work

☐ Seeing old friends ☐ Overall self-esteem ☐ Meeting new people

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:**