# Trichology
## Hair & Scalp Clinic

**Hello!**

We are so excited about the future opportunity to assist you with your hair care needs.
At the Trichology Hair and Scalp Clinic we provide more natural and holistic solutions for hair loss restoration with 27 years in combined experience in hair care, healthcare, diet, hair care restoration and education.

Trichology is a newer innovative scientific biological way of dealing with hair loss issues. Our purpose is to provide professional services utilizing premium hair care products and share advanced knowledge concerning the health and wellness of the body for changes related to hair loss and restoration.

We sincerely hope that you have a pleasant experience while visiting our clinic. Would you please take a few minutes to complete these forms to the best of your ability? Try to explain what you think may have happened to your hair and scalp, including when your issue began. Completing these forms will provide insightful information to us as we start on this journey with you for a hopeful outcome. Please note the consultation takes about 90 minutes. Therefore, if you don't complete the forms before arriving, please try and arrive 20 minutes early to do so.

Yours for Healthy Hair,

The Hair Winning Team


**Mrs. Edna Lindsey**

Certified Trichology Practitioner/
Hair Replacement Specialist

501.943.7161

3614 Market Pl Ave Suite 2
Bryant, AR 72022

www.tricho-clinic.net

hairloss@tricho-clinic.net

# Client Profile Form

Name _____ Date _____

Date of Birth _____ Age _____ Weight _____ Occupation _____

Home Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Email _____

May we text you for appointment reminders? Yes ( ) No ( )

In Case of Emergency Contact _____ Relationship _____

Home Phone _____ Cell Phone _____ Work _____

Primary Care Physician's Name _____ Phone _____

Address _____

Marital Status: ____Married ____Divorced ____Widow ____Single

If we cannot contact you by the means, you have provided above, and we would like to know if we have permission to speak to your spouse or significant other about your treatment. By signing and listing their name, you are permitting us to do so.

Name _____ Date _____

Spouse or Other _____ Date _____

Home Phone _____ Cell Phone _____ Work _____

**Patient Questionnaire**

Circle all that applies throughout the [illegible]

1. **A. Female:** What beauty salon services do you usually require? Circle all that apply to current services.

| | |
|---|---|
| Shampoo & Style | Bleach |
| Styling | Henna |
| Haircut | Manicure |
| Hair Analysis | Pedicure |
| Color | Massage |
| Permanent Wave or Chemical Relaxer | Locks |

Hair weaving (what type?) _____ Last Date _____

Braiding (what type?) _____ Last Date _____

Which styling implements do you use at home?

| | |
|---|---|
| Brush | Hot Comb |
| Flat Iron | Blow Dryer |
| Curl Iron | Hot Rollers |

Weekly Bi-Weekly Every 4 to 6 Weeks Monthly _____

**B. MALE:** What barber shop services do you usually require? Circle all that apply to current services.

| | | |
|---|---|---|
| Haircut | Microblading | Permanent Wave |
| Shave | Hairlocks | Chemical Relaxer |
| Color | Male Extensions | |
| Male Weave | Other _____ | |

When was your last visit? _____ What Services did you receive? _____

2. Name of chemical services did you receive (relaxer, color, or permanent wave services)?

_____

_____

3. Was your hair damaged at home, salon, or both?

_____

4. Have you ever lost your hair due to braiding or weaving (Traction Alopecia)? Yes No

5. Have you ever had hair due to medical reasons? Yes No If so, when and explain.

_____

_____

6. Has your hair ever been over-processed or under-processed from chemicals or hair color? Yes No If yes, when? _____

To the best of your ability, explain what you think may have happened to your hair or scalp and when your hair loss issue starts?

_____

_____

Circle all that applies:

7. Do you do any hair care services at home? Yes No If yes, what type?

_____

How often do you shampoo your hair at home? Daily Weekly Bi-Weekly Never Other

_____

_____

8. Would you please list any chemicals that you use at home?

_____

_____

9. Would you please list the brand name of products you are currently using in your home?

Shampoo _____

Conditioner _____

Hair Spray _____

Scalp Oil _____ Other _____

10. Have you ever had your hair and scalp scanned or analyzed? Yes No If yes, what treatments were recommended?

_____

_____

11. Have you received any hair implants, hair grafts, or PRP injections? If yes, what type_____

If yes, when? _____ Doctor's Name: _____

12. Have you ever had a Compass Body Scan? Yes No

13. Have you experienced any health problems? If yes, please explain _____

_____

_____

_____

**14.** Would you please list all vitamins you are currently taking and the reason for taking them?

_____

_____

**15.** Who recommended the vitamins? _____

**16.** Please list all herbs you are currently taking and the purpose.

_____

Who recommended the herbs? _____

**17.** Please list all medications you are currently taking.,

_____

_____

**18.** Do you have any drug or food allergies? Yes No If yes, please list allergies:

_____

_____

**19.** Have you had any reactions to any hair products? Yes No If yes, please list:

_____

_____

_____

Client Signature Date

1. Do you take any of the following?

   Aspirin | Sulfa drugs | Tetracycline

   Penicillin | Erythromycin | Vitamins

   Other: _____

2. Injectable numbing medications:

   Novacaibe Xylocaine Other: _____

3. Have you had any reactions to hair products, creams, ointments, or lotions? Yes No

   If yes, what? When?

   _____

   _____

4. Any known drug/environmental allergies (i.e. tape/adhesive allergies)? Yes No

   If yes, explain:

   _____

   _____

5. Have you ever had issues with anesthesia? Yes No

   If yes, when? _____

**Eyes:**

Do you wear glasses? Yes No

Do you wear contact lenses? Yes No

Do you experience blurring? Yes No

Eyes often red or inflamed? Yes No

Do you have cataracts? Yes No

Do you have glaucoma? Yes No

**Cardiovascular:**

High Blood pressure Yes No

Enlarged heart (heart failure) Yes No

Heart attack Yes No

Angina (chest pains) Yes No

Irregular beats Yes No

Heart pacemaker Yes No

Heart bypass Yes No

Valve disease or prolapsed Yes No

Other: _____

# WOMENS CHECKLIST FOR SYMPTOMS OF HORMONE IMBALANCE

***The following checklists can be used to help you and your healthcare provider determine specific symptoms of hormone imbalance.***

**Category 1: Basic Hormone Imbalance**

*Note which of the following symptoms are troublesome and/or persist over time.*

___Acne
___Bone loss
___Breast tenderness
___Cystic ovaries
___Depressed mood
___Foggy thinking
___Hair loss
___Headaches, migraines
___Heart palpitations
___ Hot Flashes
___Heavy menses
___Irritability
___Increased body/facial hair
___low libido
___Mood changes
___Night sweats
___Sleep problems
___Thinning skin
___Uterine fibroids
___Urinary incontinence
___Vaginal dryness
___Weight gain

**Number selected___**

**Category 2: Adrenal Hormone Imbalance**

*Note which of the following symptoms are troublesome and/or persist over time.*

___Aches and pains
___Allergic conditions
___Anxiety
___Autoimmune illness
___Bone loss
___Blood sugar imbalance
___Sleep disturbance
___Chronic illness
___Depression
___Elevated triglycerides
___Evening fatigue
___Infertility
___Morning fatigue
___Nervousness
___Susceptibility to infections

**Number selected___**

**Category 3: Thyroid Hormone Imbalance**

*Note which of the following symptoms and/or persist over time.*

___Aches and pains
___Anxiety
___Brittle nails
___Cold hands and feet
___Constipation
___Depression
___Dry skin
___Elevated cholesterol
___Fatigue
___Feeling cold all the time
___Foggy thinking
___Headaches
___Heart palpitations
___Inability to lose weight
___Infertility
___Low libido
___Menstrual irregularities
___Sleep disturbances
___Thinning hair
___Weight gain

**Number selected___**

**History Update:** Have you had?

___Breast cancer
___Hashimotos
___Hysterectomy
___Endometriosis
___Smoker
___Fibrocystic breasts
___Polycystic ovaries
___Uterine fibroids
___Taken hormones/birth control
___Taken thyroid medication
___Last menstrual period; when?
_____