

## HAIRCOACH CONSULT INTAKE FORM

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

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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 lo	oss?				
2. What is your main area of concern?  Hairline/Temples	Frontal area Crown (top) All Other:				
3. I'm experiencing: Thinning Receding Sheddi	ing 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 (powde	er, 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					
<ul> <li>8. Are you currently taking Propecia or Proscar?</li></ul>					
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?	ent Good Satisfactory Fair Poor				
13. How would you rate your current nutritional status?	ent Good Satisfactory Fair Poor				
14. Your current stress management skills are:	lent 🗌 Good 📗 Satisfactory 📗 Fair 📗 Poor				

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SSE PACTORS   YES   NO	HAIF	RCOACH	CONSU	LT INTA	KE FORN	/I (continued)	PAG	E 2 of 4	
Syour hair part-line widening?	TYPE		RISK FACTORS YES NO						
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 worker? (or ex-smoker) of cigarettes/cigars?  Do you have you taken prescription medication for:  High Blood Pressure?  Depression/anxiety?  Anemia (low iron)?  Have you ever been diagnosed with:  Hormone Abnormalities?  Eating Disorder?  Menopause?  15. Ever had an allergic response or adverse reaction to substances placed on your skin? Yes No Which?  Fish, Seafood Other (please list)  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 ever had a hair restoration consultation in the past? Yes   No If Yes, where?  18. Have you ever had a penetic test for Hair Loss?   Yes   No If Yes, outcome?    Jake you ever had a genetic test for Hair Loss?   Yes   No If Yes, where?    Jake you ever had a genetic test for Hair Loss?   Yes   No If Yes, outcome?    Jake you ever had a genetic test for Hair Loss?   Yes   No If Yes, by whom?    TIMISTABLE FOR HAM   SCCIPIL   CROWN   FRONT   TEMPLE   HAIRCHECKER NAME   INTINIA HAIR   Sereakage/Loss:   ARCHECKER NAME   INTINIA HAIR   Sereakage/Loss:   ARCHECKER NAME   INTINIA HAIR HAIRCHECK SETFOR +90 Days Date:   More 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 concern   SIGNATURE & ACKNOWLEDGEMENT: To the best of my knowledge, lanswered 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:   Date	S	Do any of	Do any of your "blood relatives" have thin hair or hair loss?						
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 worker? (or ex-smoker) of cigarettes/cigars?  Do you have you taken prescription medication for:  High Blood Pressure?  Depression/anxiety?  Anemia (low iron)?  Have you ever been diagnosed with:  Hormone Abnormalities?  Eating Disorder?  Menopause?  15. Ever had an allergic response or adverse reaction to substances placed on your skin? Yes No Which?  Fish, Seafood Other (please list)  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 ever had a hair restoration consultation in the past? Yes   No If Yes, where?  18. Have you ever had a penetic test for Hair Loss?   Yes   No If Yes, outcome?    Jake you ever had a genetic test for Hair Loss?   Yes   No If Yes, where?    Jake you ever had a genetic test for Hair Loss?   Yes   No If Yes, outcome?    Jake you ever had a genetic test for Hair Loss?   Yes   No If Yes, by whom?    TIMISTABLE FOR HAM   SCCIPIL   CROWN   FRONT   TEMPLE   HAIRCHECKER NAME   INTINIA HAIR   Sereakage/Loss:   ARCHECKER NAME   INTINIA HAIR   Sereakage/Loss:   ARCHECKER NAME   INTINIA HAIR HAIRCHECK SETFOR +90 Days Date:   More 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 concern   SIGNATURE & ACKNOWLEDGEMENT: To the best of my knowledge, lanswered 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:   Date	5	Is your hair part-line widening?							
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Do you routinely chemically perm or straighten your hair?  Do you drink alcoholic beverages?  Are you a smoker? (or ex-smoker) of cigarettes/cigars?  Do you/have you taken prescription medication for:  High Blood Pressure?  Depression/anxiety?  Anemia (low iron)?  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?    Have you had a hair restoration consultation in the past? Yes No If Yes, where?    Have you ever had a hair restoration consultation in the past? Yes No If Yes, where?    Have you ever had a hair transplant? Yes No If Yes, by whon?    Have you ever had a hair transplant? Yes No If Yes, by whore?    Have you ever had a hair transplant? Yes No If Yes, by whore?    Have you ever had a hair transplant? Yes No If Yes, by whore?    Have you ever had a hair transplant? Yes No If Yes, by whore?    Have you ever had a hair transplant? Yes No If Yes, by whore?    Have you ever had a hair transplant? Yes No If Yes, by whore?    Have you ever had a hair transplant? Yes No If Yes, by whore?    Have you ever had a hair transplant? Yes No If Yes, by whore?    Have you ever had a hair transplant? Yes No If Yes, by whore?    Have you ever had a hair transplant? Yes No If Yes, by whore?    Have you ever had a hair transplant? Yes No If Yes, by whore?    Have you ever had a hair transplant? Yes No If Yes, by whore?    Have you ever had a bair transplant? Yes No If Yes, by whore?    Have you ever had a bair transplant? Yes No If Yes, by whore?    Have you ever had a bair transplant? Yes No If Yes, by whore?    Have you ever had a bair transplant? Yes No If Yes, by whore?    Have you ever had a bair transplant? Yes No If Yes, by whore?    Have you ever had a bair transplant? Yes No If Yes, by whore?    Have you ever	4	Have you	Have you worn/currently wear a hair piece, hair system, or extensions?						
Do you/have you taken prescription medication for:    High Blood Pressure?	щ	Do you ro	Do you routinely color your hair?						
Do you/have you taken prescription medication for:    High Blood Pressure?	<b>⋝</b>	Do you ro	Do you routinely chemically perm or straighten your hair?						
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Have you ever been diagnosed with:   Hormone Abnormalities?   Eating Disorder?	RIP	Elevated (	Cholesterol?						
Have you ever been diagnosed with:   Hormone Abnormalities?   Eating Disorder?	ESC	Depressio	n/anxiety?						
Hormone Abnormalities?  Eating Disorder?  Menstrual Cycle Abnormality?  Recent Pregnancy?  Menopause?  No If yes   No Which?  Mo Which?  Mo Which?  Mo Which?  Mo Which?  Menopause   No Which?  Menopause?  Menopause?  Menopause?  No If Yes, outcome?  Menopause   No Which?  Menopause?  Menopause?  Menopause?  Menopause?  No If Yes, outcome?  Menopause   No Which?  Menopause   No Which?  Menopause   No Which?  Menopause   No Which?  Menopause?  Menopause?  Menopause?  Menopause?  Menopause?  No Which?  Menopause?  Menopause?  No Which?  Menopause?  Menopause   No Which?  Menopause?  Menopause?  No Which?  Menopause?  No If Yes, where?  Menopause?  Menopause?  No Which?  Menopause?  No Which?  Menopause?  No Which?  Menopause?  No Which?  Menopause   No Which?  Menopaus	PR	Anemia (lo	ow iron)?						
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HAIRCHECKER NAME   HAIRCHECKER NAME   Was Breakage/Loss:   Other:   Other:   Other:   PM or AM   Other:   PM or AM   Other:   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		-			-	1			
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RRING TO HAIR COACH OR EAY COMID ETEN EMPINITO 1 EG1 20/1/1622 AV TEVT DIC TO 1 EG1 212 2620	QUESTIONS? SPEAK WITH YOUR HAIR COACH or CALL 1.561.213.2638 or EMAIL <a href="mailto:HairCoach@BaumanMedical.com">HairCoach@BaumanMedical.com</a> BRING TO HAIR COACH OR FAX COMPLETED FORM TO 1.561.394.4522 or TEXT PIC TO 1.561.213.2638								



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NAME:				DATI	E OF FIRST VISIT:	
VISIT 2 (+90 Days)						
	OCCIPTL	CROWN	FRONT	TEMPLE	5J	
(THIS TABLE FOR HAIR					TODAY'S DATE:	
COACH USE) TAB#						
					HAIRCHECKER NAME	
нмі						
					% Breakage/Loss:	
CHANGE (+ OR -)					NEXT HAIRCHECK SET FOR +90 Days  Date:// Time:PM or AM	
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NOTES/OBSERVATIONS/ 7 Photos (OPTIONAL) —	wet hair if possib				Date:/ Time:/PM or AM  anMedical.com or text to 561.213.2638 to share with Dr. B.	
NOTES/OBSERVATIONS/  7 Photos (OPTIONAL) —  Front: looking straig	<b>wet hair if possib</b> tht at the camera,	Front: perso	n is facing forward	with head slight	Date:/ Time:PM or AM	



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NAME:						
VISIT 4 (+90 Days)						
(THIS TABLE FOR HAIR  COACH USE) TAB#	OCCIPTL	<u>CROWN</u>	FRONT	TEMPLE	TODAY'S DATE:	
нмі					% Breakage/Loss:	
CHANGE (+ OR -)					NEXT HAIRCHECK SET FOR +90 Days           Date:        /	
VISIT 5 (+90 Days)						
(THIS TABLE FOR HAIR  COACH USE) TAB#	<u>OCCIPTL</u>	<u>CROWN</u>	FRONT	TEMPLE	TODAY'S DATE:	
нмі					% Breakage/Loss:	
CHANGE (+ OR -)					SIGNUP AGAIN? NEXT HAIRCHECK SET FOR +90 Days  Date://  Time:PM or AM	
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