VANDA SALON HAIR LOSS SOLUTION

5669 Snell Avenue, Suite 428, San Jose, CA 95123
408-224-1224 email@vandasalon.net

Dear Client,

We understand that hair loss can be an emotional journey, and we want you to know that you're not alone. At **Vanda Salon Hair Loss Solutions**, we are here to support you in your quest to regain your confidence and find personalized solutions that work for you.

We are committed to helping you look and feel your best. We know that every client is unique, and that's why we take the time to listen to your concerns and goals. Your journey with us starts with this intake form, and your answers will guide us in creating a tailored plan to address your specific needs.

Please complete the attached *Client Intake Form* to the best of your ability. Your honest responses will help us provide you with the best possible care. Rest assured that your information will be kept confidential.

Once you've filled out the form, you can return it to us through email. We will reach out to schedule your initial consultation and discuss the next steps in your transformation journey.

Thank you for choosing **Vanda Salon Hair Loss Solution**s. We look forward to helping you rediscover your confidence and embrace a new, beautiful you.

Sincerely,

Vanda McCauley
Hair Replacement Specialist
Vanda Salon Hair Loss Solutions
Email@VandaSalon.net
(408) 224-1224

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CLIENT INTAKE FORM

Client Information:

Name: **Date:**

Date of Birth: **Age:**

Home Address:

City: **State:** **ZIP:**

Mobile Number: **Email Address:**

Occupation: **Work Phone Number:**

How would you like us to contact you? ☐ **Phone** ☐ **Email** ☐ **Text** ☐ **Others**

How did you hear about Vanda Salon Hair Solutions?

Would you like to receive updates on our special promos, discounts, events, etc. via email?

☐ **Yes** ☐ **No**

History of Hair Loss and Scalp Health

1. When did your hair loss start (approximately)?

2. If applicable, where on the scalp are you experiencing hair loss?

☐ All Over ☐ Front/ Hairline ☐ Crown ☐ Back/ Lower

☐ Others:

3. Is your hair loss: ☐ General ☐ Patches ☐ Both

4. Was onset of hair loss: ☐ Sudden ☐ Gradual

5. Since onset, has it gotten: ☐ Worse ☐ Better ☐ Stayed the same

6. ***Shedding*** is defined as having excessive numbers of hairs falling out daily while ***Thinning*** is defined as having less hair to cover scalp with or without excessive hairs lost each day. Is your hair:

☐ Thinning ☐ Shedding ☐ Both

7. Are your hairs: ☐ Breaking Off ☐ Coming Our At the Roots

8. Within ***6 months prior*** to the onset of hair loss:

Did you lose weight or changed your diet? ☐ Yes ☐ No

Did you experience any significant stress such as divorce, family illness, or work issues? ☐ Yes ☐ No

Did you experience any significant medical issues such as child birth, surgery, illness, or hospitalization?

☐ Yes ☐ No

Did you start or stop any hormonal or birth control pills? ☐ Yes ☐ No

Did you start on new medications ☐ Yes ☐ No

If yes, list them below:

9. Does your scalp itch? ☐ Yes ☐ No

10. Is your scalp flaking? ☐ Yes ☐ No

11. Have you been given any diagnosis for your hair loss? ☐ Yes ☐ No

12. If yes, please list them below.

13. Have you tried any form of treatment for your hair loss? ☐ Yes ☐ No

14. If yes, please list them below including the duration of the treatment and if you are still using them.

15. Have you had any recent lab works done to diagnose your hair loss?

☐ Yes ☐ No

16. What do you think is the cause of your hair loss or any contributing factors?

Hair Care and Styling

1. How often do you wash your hair?

2. What hair products do you use to wash your hair?

3. How often do you detox, exfoliate, and/or massage your scalp?

4. What hair products do you use?

5. Do you use any of the following?

☐ Hot Rollers ☐ Relaxer/ Keratin ☐ Hair Dye ☐ Rollers ☐ Curling Iron ☐ Flat Iron

☐ Other hair treatment chemicals:

6. How often do you use any of the above?

7. Do you regularly have any of the following hairstyles?

☐ Ponytails ☐ Weaves ☐ Braids ☐ Extensions

☐ Twists ☐ Headbands ☐ Sisterlocs/ Dreadlocks

8. How often do you use any of the above?

Health and Medical History

1. Are you a vegetarian? ☐ Yes ☐ No

2. Have you recently dramatically changed your diet ☐ Yes ☐ No

3. Have you seen a rash on your scalp or face? ☐ Yes ☐ No

4. If yes, please describe.

5. Are you on any type of hormone therapy? ☐ Yes ☐ No

6. If yes, what type and for approximately how long? ☐

7. Have you ever had/ do you have any of the following? Please check all that applies.

☐ Anemia
☐ Anxiety
☐ Bleeding Disorder
☐ Breast Discharge
☐ Celiac / IBS
☐ Crohn's / IBS
☐ Cystic Acne
☐ Depression
☐ Diabetes
☐ Deepening of the voice
☐ Double Vision
☐ Eating Disorder
☐ Eczema
☐ Enlargement of the clitoris
☐ Excess facial hair
☐ Fatigue
☐ GERD/ Ulcer
☐ Heart Disorder
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disorder
☐ Liver Disease
☐ Migraine
☐ Psoriasis
☐ Seborrheic Dermatitis
☐ Thyroid Disorder

☐ History of Autoimmune Disease. Please list them below

☐ Other diseases. Please list them below

8. What are your current medication/s? Please list them below.

9. Do you have any allergies? ☐ Yes ☐ No

10. If yes, list them below including your allergic reactions.

11. In the last 12 months, have you experienced any of the following? Please check all that applies

- ☐ Childbirth
- ☐ Covid-19
- ☐ Flare of Chronic Illnesses
- ☐ High Fever
- ☐ Weight Loss
- ☐ Low Iron in Blood
- ☐ Major Surgery
- ☐ Over or Under Active Thyroid
- ☐ Severe Infection
- ☐ Severe Psychological Stress
- ☐ Start or stop beta blocker medication
- ☐ Start or stop birth control pills
- ☐ Start or stop hormone treatment

12. Have you had surgery? ☐ Yes ☐ No

13. If yes, please indicate diagnosis, when and where the surgery was done.

Family History

Any family history of males with male pattern hair loss or hair thinning?

☐ Yes ☐ No

If yes, who?

Any family history of females with female pattern hair loss or hair thinning?

☐ Yes ☐ No

If yes, who?

Social History

1. Do you smoke? ☐ Yes ☐ No
2. If yes, how many sticks a day?
3. If applicable, when did you quit smoking?
4. Do you drink coffee? ☐ Yes ☐ No
5. If yes, how many cups a day?
6. What are the recent significant changes in your life?
7. Please tell us something about your current stressors in life.

For Female Clients Only

1. Are you using hormonal birth control pills?

☐ Yes ☐ No

2. If yes, what type and approximately how long?

3. If you recently stopped taking it, when did you stop?

4. If applicable, your menstrual periods are: (Please check all that applies.)

☐ Regular ☐ Irregular ☐ Light ☐ Moderate ☐ Heavy

5. Have you gone through menopause?

☐ Yes ☐ No

6. If yes, at what age?

7. Do you have excessive hair on your: (Please check all that applies)

☐ Chin ☐ Face ☐ Abdomen ☐ Around the nipples

8. Have you had difficulty becoming pregnant? ☐ Yes ☐ No

9. Have you had a hysterectomy? ☐ Yes ☐ No

10. Have your ovaries been removed? ☐ Yes ☐ No

Dear Valued Client,

We hope this message finds you well. Your trust in us as your hair regrowth treatment provider is greatly appreciated, and we are committed to helping you achieve your desired results.

To ensure the most effective and personalized approach to your hair regrowth journey, we kindly recommend that you undergo a comprehensive blood panel assessment. This critical step will enable our experienced team to gain valuable insights into your individual health and nutritional profile, which can significantly impact hair health.

The results of your blood panel will help us tailor a treatment plan specifically designed to address any underlying factors contributing to your hair loss. By focusing on your overall well-being, we aim to maximize the success of your hair regrowth treatment.

Please do not hesitate to reach out to our team to schedule your blood panel assessment or if you have any questions or concerns. Your satisfaction and the achievement of your hair regrowth goals are of utmost importance to us, and we are here to support you every step of the way.

Thank you for choosing us as your partner in your hair regrowth journey. We look forward to helping you regain confidence in your appearance and achieve the results you desire.

Sincerely,

Vanda Salon

Blood Work Screening

1. Iron levels (Hemoglobin, Feritin) ☐ In range ☐ Out of range
2. Thyroid (TSH) ☐ In range ☐ Out of range
3. Adrenal (ACTH) ☐ In range ☐ Out of range
4. Lupus (ANA) ☐ In range ☐ Out of range
5. Vitamin A ☐ In range ☐ Out of range
6. Vitamin B ☐ In range ☐ Out of range
7. Vitamin K ☐ In range ☐ Out of range
8. Vitamin D ☐ In range ☐ Out of range
9. Zinc ☐ In range ☐ Out of range
10. Androgens - For Women (DHT): DHEA-S ☐ In range ☐ Out of range
11. Androgens - For Men (DHT): DHEA ☐ In range ☐ Out of range