Date:	**Natural Wellness Center - CONFIDENTIAL** **Hair Loss Control Clinic**	**QBPOS:** ☐ Log ☐ **Email**: ☐ **File** ☐	**Referred By:**

Name: _____Sex: M / F Date of Birth: _____Age:_____

Address: _____

Phone: *Main #:*: _____

Cell: _____

City: _____Zip:_____

Email:_____

How did you hear about us?_____

What are your reasons for coming in today? Main Health Concerns and Health Goals (Please List)?

1._____ **2.**_____ **3.**_____

Put a check next to your daily habits:

- ❑ Skip meals
- ❑ Eat too much/too fast
- ❑ Addicted to carbs
- ❑ Eat junk food/fast food
- ❑ Eat out # wk_____
- ❑ Emotional eating
- ❑ Drink alcohol #_____
- ❑ Drug Use/Recreational Drugs
- ❑ Constant Snacking
- ❑ Smoke/Past Smoker #_____
- ❑ Strong cravings (sweet/salt/fat)
- ❑ Not enough water #_____
- ❑ Energy: 1 2 3 4 5(best)
- ❑ Caffeine Intake:_____
- ❑ Sleep Hours/Day:_____
- ❑ Exercise/Week:_____
- ❑ T.V hours/Day_____
- ❑ Daily Stress: 1 2 3 4 5(high)

Do you have any health issues?

- ❑ High Cholesterol
- ❑ High Blood pressure
- ❑ Heart Disease
- ❑ Stroke
- ❑ Heart Failure
- ❑ Irregular Heart Beat
- ❑ Coronary Artery Dis.
- ❑ Anemia
- ❑ Diabetes
- ❑ Arthritis
- ❑ Joint Problems
- ❑ Hormonal Imbalance
- ❑ Thyroid Disease
- ❑ Depression
- ❑ Weight Problem
- ❑ Cold/Flu
- ❑ Migraines/Head Aches
- ❑ Digestive Problems
- ❑ Gas/Bloating
- ❑ Constipation or Diarrhea
- ❑ Asthma
- ❑ Allergies:_____ _____ _____ ___
- ❑ Shellfish Allergy
- ❑ Medications: _____ _____ _____ _____
- ❑ Supplements: _____ _____

Presently Undergoing Medical Treatment for:_____

Previous Surgery with General Anesthesia: Yes / No

Bloodwork: Have you had any of these tests done in the past year? ☐CBC w/Diff ☐Thyroid Panel ☐Glucose Tolerence ☐Ferritin/Iron test ☐Hormone: DHEA/Testosterone/Estrogen ☐Other_____

Females Only: 1.Female issues? Yes / No 2.Post Menopausal? Yes / No 3.Pregnant/Nursing or Planning to? Yes/No

Males Only: 1.PSA blood test for prostate cancer? Yes / No 2.Do you have and Enlarged prostate or prostate cancer? Yes / No

Diet & Nutrition: Good/Ok/Bad Are you vegetarian: Yes / No Serving red meat per week :_____

Conditions of Hair and Scalp

Scalp: Dry / Oily
Redness Yes / No
Dandruff Yes / No
Painful itchy scalp: Yes / No
Itchy scalp only: Yes / No
Areas of hair loss: All over scalp / Front / Crown/Top

Do you pull your hair? Yes / No
Bumps or raised areas: Yes / No
Goose Bump feeling: Yes / No
Recurrent attacks of patchy loss: Yes / No
Hair of different lengths: Yes / No

Alopecia Areata____ Totalis___ Universalis___

Did you lose any hair at a young age? Yes / No How old were you?_____ Was loss Sudden or Gradual?(Circle)

Any loss of hair on body? Yes___No ___ What area(s)_____

Is your hair loss getting worse_____ How many hairs lost per day? _____

What kind of shampoo do you use? _____ Conditioner_____Use time per Week?_____

Do you use a hair dryer? Yes/ No What temperature? Hot/Medium/Cool Use a towel to rub dry? Yes/No

Is your hair loss caused by any medical problems or medications that you are aware of? _____

HEREDITY Does hair loss run in your family? Yes___ No ___

	BALD	THINNING HAIR	NOT BALD	UNKNOWN	
Parents	____	____	____	____	**Family History:**_____
Grandparents	____	____	____	____	_____
Siblings	____	____	____	____	_____
Aunt/Uncle	____	____	____	____	_____

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

Transplants ___ Scalp Treatments ____ Hair Replacement or weaves____

Over the counter products____ Prescription products___ Avacor ____

Minoxidil_____% Other _____ Clubs or Hair Loss Clinics _____

How much does your hair loss bother you? Slightly___ Moderately___ Highly___

Would you like to consider using prescription strength topicals and pills if you could get better results? Y / N

What are your goals and expectations? Prevent further loss/Gain back hair quickly/Gradually gain back some hair/Other

Knowing that treatment options may take 6 months or more to show success, are you willing to wait that long? Yes / No

PAST MEDICAL HISTORY (list any past hospitalizations, surgeries, illnesses, immunizations)_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

I have read the Notice of the Uses and Disclosures of Protected Health Information (the "Notice") that is posted in the office. I was informed that I may also obtain a copy of the Notice from the receptionist. I hereby acknowledge that I reviewed from the Natural Wellness Center a copy of the Notice.

CONSENT FOR CONSULTATION

I am being evaluated by the Natural Wellness Center (NWC), and understand I will first undergo a comprehensive preliminary evaluation by one of our experienced hair loss consultants and doctor should I need a prescription product. This evaluation will determine if I am a suitable candidate for treatment. I understand that the cost of the initial evaluation is FREE and NWC has waived its $250 consultation fee. This preliminary evaluation will include a complete and thorough medical and hair loss questionnaire, a scalp evaluation if available which includes standard medical photography (no face shown), and microscopic photography for which I give consent. I also understand that although NWC has had many extremely successful clients, each client is different and like any medical or cosmetic treatment results will vary depending on a large number of factors. I acknowledge that it is my responsibility to inform NWC of any changes in my medical condition no matter how slight and agree to read all product labels and treatment information provided to me so I can understand my treatments and get the best possible results. I understand some general recommendations will be made based on the initial consultation and determine if I am a candidate for a prescription treatment program.

Print Your Name Your Signature Date

Area For Doctors Notes:

CC1:

S&S:
Hair Scale: WOMEN: I-1/I-2/I-3/I-4/II-1/II-2/III/ADV/Frontal
MEN: 2 / 2A / 3 / 3A / 3V / 4A / 5 / 5A / 5V / 6 / 7

Scalp Condition: Flaky / Oily / Dry Pull Test: 0-4 / 4+ hairs

Scope Eval: Cycling Down // Sebum Buildup // Broken Ends

Scope Pics: ○50mm ○200mm ○Dig Pics
○Crown _____ cm ○Top_____ cm ○Frontal_____ cm
Helps/Worse:

Other Notes/Observations:

Diagnosis: Alopecia Areata / Totalis / Universalis / General Hair Loss / Androgenetic

Plan: Laser Option 1 | 2 | 3 | 4 Investment:$ Paid date: _____
2x week / 2 mo. (8wks) // 1x week / 4 mo. (16wks) // 1x every-other-week / 6 mo. (28 wks)

Laser Trx: 60 | 46 | 32 | 20 Program Length: 1 Year // 6 Months // 10 Weeks

Lab Tests: ○ CBC ○ Hormone Panel/Thyroid ○ Other Blood test (DLS)

Supplements: (Dispense ALL products at time of purchase) ○ 1 Year Supply of Products

○ *HLCC Scripts Scalp Therapy	○ HLCC Topical Nutrients - Coenzyme
○ *DHT Blocking Shampoo 8oz.	○ HLCC Scripts Shampoo 8oz.
○ *HLCC Scripts Complete	○ AA PLUS
○ *Minoxidil Cream 5% w/Saw	○ Maximum Growth Therapy
○ Minoxidil 10%/15% and 10%/15 w/ Saw	○ HLCC Scripts Conditioner
○ Men can add Propecia or 1.25 mg Finasteride	○ Vitamin Plus Conditioning

○ IV Nutritional Therapies
○ Hand Held Laser – Home Use; Once to Twice Daily ○ Other:
○ Micro-Needling – Minoxidil, Platelet Rich Plasma ○ Referral: Dermatologist

F/U Mo:1
F/U MO:3
F/U MO:5
F/U MO:6
F/U MO:7
F/U MO:9
F/U MO:10
F/U MO:11
Other:

F/U MO:2
Scalp Cond'n: F / O / D Pull Test: 0-4 / 4+
Cycling Down // Sebum Buildup // Broken Ends
Scope Pics: ○C ____ cm○T____ cm ○F___ cm

F/U MO:4
Scalp Cond'n: F / O / D Pull Test: 0-4 / 4+
Cycling Down // Sebum Buildup // Broken Ends
Scope Pics: ○C ____ cm○T____ cm ○F___ cm

F/U MO:8
Scalp Cond'n: F / O / D Pull Test: 0-4 / 4+
Cycling Down // Sebum Buildup // Broken Ends
Scope Pics: ○C ____ cm○T____ cm ○F___ cm

F/U MO:12
Scalp Cond'n: F / O / D Pull Test: 0-4 / 4+
Cycling Down // Sebum Buildup // Broken Ends
Scope Pics: ○C ____ cm○T____ cm ○F___ cm

1	2	3	4	5	6	7	8
9	10	11	12	13	14	15	16
17	18	19	*20	21	22	23	24
25	26	27	28	29	30	31	*32
33	34	35	36	37	38	39	40
41	42	43	44	45	*46	47	48
49	50	51	52	53	54	55	56
57	58	59	*60th	61	62	63	64