Body, Soul & Spirit A Trichology Clinic
A Jarmstead Unlimited Corporation
Est. Lic. #A215165

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CASE HISTORY PROFILE

Date _____ Client Name _____ ID# _____

How long have you been losing your hair? _____

Current daily hair loss: ☐ **30-50 stands** ☐ **50-80 strands** ☐ **80 strands & up**

Shampoo frequency: ☐ **Daily** ☐ **Every other day** ☐ **Twice Weekly** ☐ **Other**

Shampoo presently used _____ Conditioner presently used _____

Do you dye, tint, bleach, relax, straighten, or have a permanent wave? **Yes** **No**

Other hair and scalp products used: (examples: hair spray, vitamins, scalp cleaners, etc.) _____

_____

Have you ever employed the services of everyone to correct your hair loss? **Yes** **No**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widow/Widower**

# of dependant children _____ Ages _____ _____ _____ _____ _____

Work Environment ☐ **Outside** ☐ **Inside** ☐ **Dirty** ☐ **Clean** ☐ **Paint, Chemicals, etc.** ☐ **Hot, Humid, etc.**

Family Hair Loss History: **Father's** _____ **Mother's** _____

Your Grandfathers	_____	_____
Your Grandmothers	_____	_____
Your Aunts	_____	_____
Your Uncles	_____	_____
Your Brothers	_____	_____
Your Sisters	_____	_____

Medical History: Date of last physical exam? _____ Date of last X-Ray? _____

Within the last six months, have you undergone treatment for nay of the following conditions? Indicate the date.

Heart Trouble	Y	N	
Hypertension (high blood pressure)	Y	N	
Low Blood Pressure	Y	N	
Thyroid Imbalance	Y	N	
Pituitary Imbalance	Y	N	
Blood Disorder	Y	N	
Seizure Disorder (epilepsy)	Y	N	

Anemia	Y	N	
Diabetes	Y	N	
Keloid (scar) Formation	Y	N	
Psoriasis	Y	N	
Skin or Scalp Disorder	Y	N	
Body Building Steroids	Y	N	

Other medical treatments. If yes, list here _____

Do you now, or have you:

Worn a hairpiece	Y	N
Had transplants	Y	N
Had implants or fusions	Y	N
Been on a diet	Y	N
Lost or gained more than 15 lbs in the past year	Y	N
Been eating a well balanced diet	Y	N
Been taking daily vitamins or supplements	Y	N
Had any allergies	Y	N

Had allergies to drugs or medicine	Y	N
Had a recent accident	Y	N
Had recent surgery	Y	N
Had you scalp injured	Y	N
Been under physician's care	Y	N
Been using drugs or medication	Y	N
Had excessive emotional strain	Y	N
Been in good health	Y	N

►Habits:

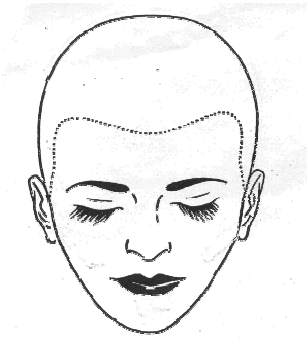
	Never	Occasional	Often
Alcohol	_____	_____	_____
Tobacco	_____	_____	_____
Drugs	_____	_____	_____
Candy, Soft Drinks, etc.	_____	_____	_____

Is your scalp: Oily	Y	N
Dry	Y	N
Flaky or crusty	Y	N
Red or inflamed	Y	N

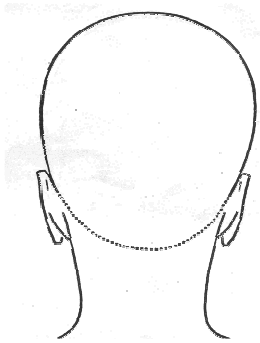
Itchy	Y	N
Women Only: Pregnant	Y	N
Menopause	Y	N
Balanced menstrual cycles	Y	N

Oral Contraceptives	Y	N
Are you taking hormones	Y	N
Hysterectomy	Y	N

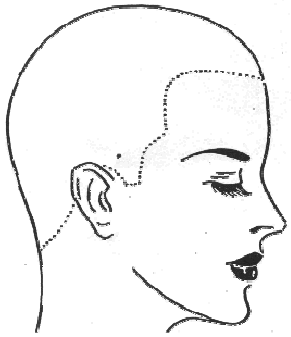
Diagram/Photographs: Please indicate and describe your problem area(s) below. If possible, enclose photographs.



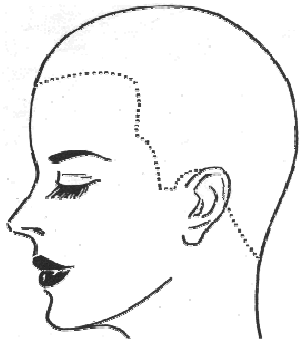
FRONT/TOP



BACK/TOP



RIGHT SIDE



LEFT SIDE

FRONT/TOP: _____

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BACK/TOP: _____

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RIGHT SIDE: _____

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LEFT SIDE: _____

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