



SALON & SPA
Believe • Beyond • BeYou

Date: _____

Male Female

CLIENT INTAKE FORM - HAIR

Name _____ Date of Birth _____

Address _____ City _____

State _____ Zip _____ Email _____

Phone _____ Referral _____

Emergency Contact _____ EC Phone _____

Physician _____ Health Insurance Carrier _____

What is your current hair length? Short Ear-Length Shoulder-Length Mid-Back Length Lower Back+

Is your hair currently natural? Yes No

How would you describe your scalp? Dry Normal Oily

How would you describe the current condition of your hair? Healthy Slightly Damaged Dry/Damaged

Shampoo frequency? Daily Weekly Bi-weekly Monthly

Condition frequency? Daily Weekly Bi-weekly Monthly

Deep condition frequency? Daily Weekly Bi-weekly As Needed

Are you currently taking medications? If so, please list: _____

How would you describe the curl pattern of your hair? Straight Wavy Curly Kinky-Curly Kinky

How would you describe the density of your hair? Fine Medium Thick

Are you currently taking any medication that has side effects that can cause hair thinning and/or hair loss? If so, which one(s)? _____

Do you have now, or have had in the past, any problems with hair loss? Yes No

What are your long-term hair goals? More Length More Moisture Permanent Color Other: _____

Is there anything you need to improve your current method of hair care?

Daily Regimen Hair Products Eating Habits Water Intake

I have read the above information and have given an accurate account of the questions. If I have any concerns, I will address these with my stylist before the service. I give permission to my stylist to perform the hair service we have discussed and will not hold the stylist nor b Salon & Spa accountable for any liability that may result from this treatment. I understand that my stylist will take every precaution to minimize or eliminate negative reactions as much as possible.

Client Signature _____ Date _____

Consent to Treatment of Minor: By signature below, I hereby authorize b Salon & Spa to Administer massage, body-work or facial to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____

