Hair Loss Consultation Intake Form

Patient Information

Name: ____Signature:_______________________________

Date of Birth: ______________________

Gender: ☐Male ☐Female ☐Other

Date: ________________

Referred by: __________________________________

1. Chief Concern

What is your main concern about your hair? _______________________________________

When did you first notice hair loss? ______________________

Has the hair loss been: ☐Gradual ☐Sudden ☐Intermittent

Is it: ☐Shedding ☐Thinning ☐Patchy ☐Receding ☐Bald spots

2. Hair Loss Pattern

Where is the hair loss most noticeable? ☐Frontal hairline ☐Crown ☐Temples ☐Diffuse ☐Sides ☐Other: _________

Any loss of: ☐Eyebrows ☐Eyelashes ☐Body hair
Do you notice increased hair on pillow/shower/brush? ☐Yes ☐No
Any itching, burning, pain, or tenderness? ☐Yes ☐No If yes, describe:
____

3. Medical & Family History

Family history of hair loss? ☐Yes ☐No If yes, who? ___________________________________
Any history of: ☐Thyroid disease ☐Anemia ☐Autoimmune disease ☐PCOS ☐Menopause
☐Major illness/high fever ☐Surgery ☐COVID/infection (past 6–12 months)
Details: ____

4. Medications & Supplements

List current medications: ____

____
Any recent new medications? ☐Yes ☐No
Supplements/vitamins: ____
Have you used: ☐Minoxidil ☐Finasteride ☐Spironolactone ☐PRP ☐Exosomes ☐Other:
____

5. Hormonal & Menstrual History (for female patients)

Are your periods: ☐Regular ☐Irregular ☐Absent
Any recent pregnancy or childbirth? ☐Yes ☐No Date: _________

On birth control or HRT? ☐Yes ☐No Type: ______________________
Any increase in acne, chin hair, or weight changes? ☐Yes ☐No

6. Diet & Lifestyle

Describe your diet: ____________________________________
Any recent weight loss or restrictive eating? ☐Yes ☐No
Do you eat meat? ☐Yes ☐No

Are your sleep habits good/normal?____
Stress level (1–10): _____ Exercise: ☐Rarely ☐Occasionally ☐Regularly

7. Hair Care & Cosmetic History

How often do you wash your hair? ___________________
What shampoo/conditioner or topical products do you use? ______________________
Do you use: ☐Tight hairstyles ☐Heat styling ☐Chemical straightening ☐Coloring

☐Extensions ☐Wigs
Have you had: ☐PRP ☐Microneedling ☐Low-level Laser or LED therapy ☐Exosome therapy ☐Hair transplant

8. Review of Systems

☐Fatigue ☐Cold intolerance ☐Weight changes ☐Acne ☐Irregular periods
☐Scalp itching ☐Scalp pain ☐Dandruff ☐Patchy hair loss ☐Excess hair elsewhere

9. Labs & Diagnostics (if available or ordered)

Test	Date	Result
CBC		
Ferritin		
TSH / Free T4		
Vitamin D		
Zinc		
Testosterone / DHEA-S		
LH / FSH / Prolactin		

10. Treatment Goals & Expectations

Interested in: ☐Topical/Oral medication

☐PRP/Exosome

☐Laser / LED light therapy

☐Transplant

☐Nutrition
Goals for treatment: ____
____

Clinician Assessment (for provider use)

Pattern/type suspected: ☐Androgenetic ☐Telogen effluvium ☐Alopecia areata ☐Scarring ☐Other: _________
Notes/Plan/Recommendations:

- Minoxidil _____mg / _____%; oral / topical; once / twice daily
- Finasteride _____mg / ____%; oral / topical; once / twice daily
- Nutritional supplements: ________________________________; directives: ____
- Rion Plated Hair serum: 1-2 dropperfuls to thinned areas, rubbed in 1-2 times daily
- Low-level ultrasound with exosomes, 4 treatment series: 3 treatments within 2-3 months, then the 4th treatment 6 months after the 1st treatment. Thereafter, one treatment every 6-12 months. (Each treatment is painless and takes about 30min.; in clinical trials, found to be 40% more effective at growing hair than PRP)
- Low-level laser light/ LED light therapy, red (660nm) & orange (620nm); eg. Revian cap
- Hair transplants (Follicular Unit Extractions, FUE)
- Shampoo and conditioner recommendations: ____________________________________