INTEGRATIVE HEALTH AND WELLNESS INC.
Trichological Consultation Questionnaire

Patient Name: ____ Date: _____/_____/______

DOB: _____/_____/_______ Age: _____ Gender: (F) (M) (FTM) (MTF) (Non-Conforming) (Non-Binary)

Address: ____

Cell Number: (___) _____- ________ Email Address: ______________________________________

Occupation: ____

General Health: (Excellent) (Good) (Fair) (Poor)

Allergies: ____

Primary Concern: ____

____ # of Years: _____

Where on your scalp do you feel you have lost hair? □ Temples □ Front Hairline □ Front Half of Head

□ Sides of Head (Above Ears) □ Very Top of Head □ Back of Head □ Other: ______________________

Is your Scalp Itching? □ Yes □ No

Do you ever get a Burning/Tingling sensation in the scalp? □ Yes □ No

Does your scalp ever feel tender, sore or bruised? □ Yes □ No

Does your hair texture feel different? □ Yes □ No

Do you experience flaking/dandruff? □ Yes □ No

Do you feel your scalp is more red than what you would consider normal? □ Yes □ No

Do you feel that you are shedding more hair on a daily basis than you used to? □ Yes □ No

Do you ever get pimples in your scalp? □ Yes □ No

How often do you shampoo your hair? □ Few times a day □ Once a day □ 6 x a week □ 5 x a week

□ 4 x a week □ 3 x a week □ 2 x a week □ 1 x a week □ 1-2 x a month □ Less than 1 x a month

Do you feel that your eyebrow/Eyelash density is less than 10 years ago? □ Yes □ No

Women Only:

Child Bearing Patients Only: Number of Children: ______ Ages: ________________________________

Menarche □ Yes □ No Age: ______ Menopause □ Yes □ No Age: ______

(Total Hysterectomy) (Hysterectomy w/ Oophorectomy) (Oophorectomy) (Radical Hysterectomy)

Year Performed: ___ (HRT): □ Yes □ No If yes, name and date started/stopped: __________________

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Family History: (Hair Loss/Skin Conditions/Autoimmune Diseases) Unknown: □ Yes □ No

Mother: ____________________________________ Father: ____________________________________

Sister: ______________________________________ Brother: ___________________________________

Maternal Grandmother: ________________________ Maternal Grandfather: _____________________

Paternal Grandmother: _________________________ Paternal Grandfather: ______________________

Maternal Aunt: _______________________________ Maternal Uncle: ___________________________

Paternal Aunt: ________________________________ Paternal Uncle: ____________________________

Hormones: Abnormal Blood Test Results □ Yes □ No

If yes, provide name, level(s) and date(s) taken: ____

____

***If possible please bring in copy of most recent bloodwork and any results from at least 6 months prior to onset of current complaint.**

Prescription Hormones: □ Yes □ No

If yes, name and date started/stopped: ____

Non-Prescription Hormones: □ Yes □ No

If yes, name and date started/stopped: ____

Birth Control Pills: □ Yes □ No

If yes, name and date started/stopped: ____

Personal Health History: ____

____

Anemia: □ Yes □ No (Sickle Cell) (Hemolytic) (Aplastic) (Pernicious) (Thalassemia) (<Iron/<Ferritin)

If yes, type and date of onset: ____

Medication(s) Name/Dates: ____

____

Diabetes: □ Yes □ No (Type I) (Type II) (Latent Autoimmune Diabetes in Adults - LADA) (Gestational)

If yes, type and date of onset: ____

Medication(s) Name/Dates: ____

____

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Thyroid: □ Yes □ No (Hypothyroid/Hyperthyroid/Hashimoto's/Cancer)

If yes, date of onset: ______________________________

Medication(s) Name/Dates: ______________________________

____

Thyroid Surgery: □ Yes □ No (Removal) (Chemotherapy) (Radiation)

If yes, type and date(s): ______________________________

____

Autoimmune Disorder: □ Yes □ No (MS) (Lupus) (Celiac) (RA) (Sjögren's) (Vasculitis) (Sarcoidosis) (etc._)

If yes, type and date of onset: ______________________________

Medication(s) Name/Dates: ______________________________

____

PCOS: □ Yes □ No (Insulin Resistance) (Adrenal) (Inflammatory) (Post-Pill)

If yes, date of onset: ______________________________

Medication(s) Name/Dates: ______________________________

____

Pelvic Surgery: □ Yes □ No

If yes, type and date(s): ______________________________

____

Vitamin Deficiencies: □ Yes □ No (Vitamin >A/<D3)

If yes, type and date of onset: ______________________________

Supplementation Name/Dates: ______________________________

____

Smoking History: □ Yes □ No Past/ Present (Vape/Cigarettes/Marijuana/Other: ________________)

If yes, how long and amount daily: ______________________________

____

Medication: □ Yes □ No (*If ever prescribed Lithium - please provide exact amount and dates)

If yes, Medication(s) Name(s)/Date(s): ______________________________

____

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Diet: (Healthy) (Unhealthy) ____
(Standard) (Gluten Free) (Vegetarian) (Pescetarian) (Lacto Vegetarian) (Ovo-Lacto Vegetarian) (Vegan) (Raw) (Mediterranean) (Low-carbohydrate) (Paleo) (Ketogenic) (Low-Fat) (Intermittent Fasting) (Fasting)

Sources of protein: ____ How Much Daily? _____ Grams

Weight Loss/Weight Gain: □ Yes □ No If yes, how much and when: ________________________________

Excessive Stress: □ Yes □ No

If yes, type and date of onset: ____

Strategy for dealing with stress: (Meditation) (Exercise) (Hobby)

(Other: ____)

Medication(s) Name/Dates: ____

____

In Therapy: □ Yes □ No If yes, start/stop date: ____

Hairdressing Practice:

(Relaxers) (Straighteners) (Chemical Processes) (Dyes): If yes, start and stop dates: __________________

____

(Weaves) (Caps) (Hair Ties) (Braids) (Twists) (Wigs) (Hats) (Hair Pieces) (Powders): If yes, Start and stop dates: ____

Surgical Hair Restoration: FUT/FUE □ Yes □ No If yes, dates: _____________________________________

Previous Doctor Visits for this specific complaint: □ Yes □ No

(Dermatologist) (Endocrinologist) (Immunologist) (Plastic Surgeon) (General Practitioner) (Gynecologist)

If yes, date(s): ____

Medication(s)/Treatment/Steroid Injections/Surgeries/Scalp Biopsy: _______________________

____

Ever used Accutane (Isotretinoin) in the past for any reason including for treatment of acne? □ Yes □ No

Trichologist Visit: □ Yes □ No **Previous Hair Treatments for hair loss or scalp disorders:** □ Yes □ No

If yes, type and start/stop date: ____

Medication(s)/Treatment/Surgeries (Name/Dates): _____________________________________

____

____

Current Hair Care Products: ____

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For Office Use Only:

Hair Color: (Black) (D. Brown) (L. Brown) (Auburn) (Red) (Brown/Blonde) (Blonde) (Grey/Silver/White)
(Dyed Color: ___________________________Date: ____________) If Dyed, also circle original color.

Hair Texture: (Fine) (Course)

Hair Type: (Straight) (Wavy) (Curly) (Coily) - (Oily) (Dry) (Combination) (Normal)

Scalp/Skin Disorders: (Folliculitis) (Dandruff) (Eczema) (Seborrheic Dermatitis)

(Other: ____) How Long? ____

Nails: (Normal) (Brittle) (Splitting) (Pitted) (Ridged Horizontal) (Ridged Vertical) (Thin) (Thick)

(Brown) (Yellow) (White) (Other: _______________________________________) How Long? ____

Skin: (Normal) (Oily) (Dry) (Combination) (Sensitive) (Scaly) (Red Spot) (Skin Moles)

(Acne: Mild/Moderate/Severe – Location: Face/Back/Chest/Arms/Legs/Abdomen/Buttocks)

(Hyperpigmentation) (Hypopigmentation) (Other: _________________________) How Long? ____

Skin Color without sun exposure: (Black) (D. Brown) (L. Brown) (Olive/Tan) (Reddish) (White) (Very Pale)