



Client Intake Form



Client's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____

Email Address: _____

Date Of Birth (Month/Day): _____

Where did you hear about us? _____

I would like to receive emails with promotions and discounts ☐ yes ☐ no

Do you have sensitive scalp or have you ever had a negative reaction to chemicals on your scalp? ☐ yes ☐ no

If yes, explain: _____

Please list any medications you are on: _____

Please list past chemical services you have had on your hair: _____

Please list all that apply to your hair type:

- | | | |
|-----------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> Straight | <input type="checkbox"/> Oily | <input type="checkbox"/> Fine |
| <input type="checkbox"/> Wavy | <input type="checkbox"/> Dry | <input type="checkbox"/> Medium |
| <input type="checkbox"/> Curly | <input type="checkbox"/> Normal | <input type="checkbox"/> Thick |
| <input type="checkbox"/> Frizzy | <input type="checkbox"/> Combo | <input type="checkbox"/> Course |

Do you suffer from any of the following conditions?

- | | |
|---|--|
| <input type="checkbox"/> Psoriasis of the Scalp | <input type="checkbox"/> Eczema of the Scalp |
| <input type="checkbox"/> Alopecia | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Hair Loss | |

Salon New Client Information Form

Ian Pickup



Salon New Client Information Form:

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