CONSULTATION FORM - **HAIR LOSS**

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| Date: | Click or tap to enter a date. |

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| First and last name:  | Click or tap here to enter text. |
| Gender: | Choose an item. | Age: | Click or tap here to enter text. |
| Height: | Click or tap here to enter text. | Weight: | Click or tap here to enter text. |
| Occupation: | Click or tap here to enter text. | Marital Status:  | Choose an item. |
| Address: | Click or tap here to enter text. |
| Phone: | Click or tap here to enter text. |
| E-mail: | Click or tap here to enter text. |

Please write your e-mail address legibly. The program will be e-mailed to you.

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| How did you hear about us? Google, Instagram, Facebook, Twitter, friends, other? |
| Click or tap here to enter text. |
| Please provide your transaction details (date of deposit, name, surname and your PayPal e-mail address):  |
| Click or tap here to enter text. |
| If you already have received a treatment program from us, please indicate how many courses you received and how effective was your previous course: |
| Click or tap here to enter text. |

Please figure out the condition of your hair based on the shapes below:

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|[ ] [ ] [ ]   |[ ] [ ] [ ] [ ] [ ]

**Make sure to take some clear photos of your hair condition and submit it along with the form.**

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| Are your parents facing hair loss or baldness? Please explain. |
| Click or tap here to enter text. |

What type of hair do you have? [ ]  Dry [ ]  Normal [ ]  Oily

Do you have dandruff? [ ]  Yes [ ]  No

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| How long have you been suffering from hair loss? |
| Click or tap here to enter text. |

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| Are you pregnant or breastfeeding? |
| Click or tap here to enter text. |
| If you have ever used any anti-hair loss products, write down the name of the products and the result. |
| Click or tap here to enter text. |
| Do you smoke? If so, on average, how many cigarettes per day? |
| Click or tap here to enter text. |
| Do you drink alcohol? If so, how much? |
| Click or tap here to enter text. |

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| Do you exercise? What kind of exercise and how many hours per week? |
| Click or tap here to enter text. |

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| How many hours do you sleep at night? Do you have problems such as insomnia or excessive sleepiness? Please explain. |
| Click or tap here to enter text. |

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| Do you have a stressful life? |
| Click or tap here to enter text. |

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| If you have any disease, please fully explain. |
| Click or tap here to enter text. |

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| If you have any mental disorders such as anxiety, depression, obsession, phobia, mood swing, anger management problems, restlessness, etc., please fully explain. |
| Click or tap here to enter text. |

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| Please list all medications or natural supplements you are currently taking, and for what conditions? |
| Click or tap here to enter text. |

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| Do you have any medication or food allergies? |
| Click or tap here to enter text. |

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| Write your current diet plan (Breakfast, lunch, dinner, snacks, etc.) |
| Click or tap here to enter text. |

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| How many caffeinated beverages do you consume per day? |
| Click or tap here to enter text. |

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| At the end, if you have any additional explanation about your physical or mental condition, please write. |
| Click or tap here to enter text. |

Name and Signature:

Click or tap here to enter text.

Please draw your signature here

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1. The applicant is responsible for the accuracy of the information in the form. The applicant must complete the treatment form accurately and keep the physician fully informed of his or her condition, illnesses and medications.
2. I allow the use of my photos on Dr. Nasirzadeh's website and social networks.
3. I have read the FAQ page thoroughly, and I am fully aware of the treatment process and the chance of getting a result.