HAIR AWAKENING
Hair Loss Treatment &
Beauty Therapy Clinic

CONSULTATION FORM – **IMMUNE SYSTEM**

Date: / /

First and last name:

Gender:	Age:	Height:
Weight:	Occupation:	Marital Status:
Phone:	E-mail:	Address:

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

How did you hear about us? Google, Instagram, Facebook, Twitter, friends, other?

Please provide your transaction details (date of deposit, name, surname and your PayPal e-mail address):

If you already have received a treatment program from us, please indicate how many courses you received and how effective was your previous course:

Please indicate any vaccine such as Influenza, HPV, etc. that you have been injected in the last five years and its approximate year of injection.

Are you suffering from fatigue and lack of energy?

Do you easily catch a cold?

Do you often suffer from constipation or diarrhea? If so, please explain.

How healthy do you feel in general? Give it a number from 1 to 5? (5 is complete health)

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Do you have any medication or food allergies?

Do you smoke? If so, on average, how many cigarettes per day?

Do you drink alcohol? If so, how much?

Do you use drugs? What kind, and how often?

Are you pregnant or breastfeeding?

Do you exercise? What kind of exercise and how many hours per week?

How many hours do you sleep at night? Do you have problems such as insomnia or excessive sleepiness? Please explain.

Do you have a stressful life?

If you have any disease, please fully explain.

Please write a complete history of your parents' illnesses such as cancer, diabetes, hypertension, kidney problems, etc.

If you have any mental disorders such as anxiety, depression, obsession, phobia, mood swing, anger management problems, restlessness, etc., please fully explain.

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Please list all medications or natural supplements you are currently taking, and for what conditions?

Write your current diet plan (Breakfast, lunch, dinner, snacks, etc.)

How many caffeinated beverages do you consume per day?

At the end, if you have any additional explanation about your physical or mental condition, please write.

Name and Signature:

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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.