HAIR AWAKENING
Hair Loss Treatment &
Beauty Therapy Clinic

CONSULTATION FORM - **SKINCARE**

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.

Please send along with the form a few photos of your face and neck that were taken in full light and clarity.

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 select your treatment:

☐ Facial & Neck Rejuvenation ☐ Skin Care and Anti-Aging

☐ Acne Treatment ☐ Eczema Treatment

Please explain your skin problems:

Have you ever received chemical peels, laser services, microdermabrasion, dermabrasion, botox, juvederm, dermal fillers or any other skin treatments in the last two years? If Yes, please explain and mention the time.

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What kind of skincare products do you currently use?

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

Do you have skin allergies? Do you have any medication or food allergies?

Have you used or been prescribed any medications (topical or oral) for acne control? If yes, please specify what and date last used:

Are you exposed to extreme or prolonged sunlight?

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What kind of skin do you have? ☐Dry ☐ Normal ☐Oily?

Have you received any of these hair removal services in the last 45 days?
☐Waxing ☐Sugaring ☐Threading ☐Electrolysis/Laser ☐Depilatory Cream
☐Shaving ☐ None

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

Did you drink alcohol? How much?

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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 physical or mental illnesses, please fully explain.

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

How many caffeinated beverages do you consume per day?

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WOMEN'S QUESTIONS:

Are you pregnant or breastfeeding?

Do you take birth control pills? If yes, specify the type and amount of use.

Are you going through menopause? Are you experiencing any symptoms during menopause? Please explain.

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MEN'S QUESTIONS:

What is your current shaving system?
☐Razor ☐Electric ☐Other:

Do you experience irritation from shaving?

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.