**REVIVE! CLIENT PROFILE**

**NAME** **BIRTHDATE**

**CONTACT INFO**

**MOBILE PHONE:**

**HOME: PHONE:**

**WORK PHONE:**

**ADDRESS:**

**EMAIL:**

**HOW DID YOU HEAR ABOUT REVIVE!?**

**WHAT DO YOU ENJOY MOST ABOUT VISITING ANY SALON?**

**PERSONAL DATA**

**DO YOU HAVE A PARTICULAR HAIR OR SCALP GOAL YOU WISH TO ACHIEVE?**

**HOW OFTEN IS YOUR HAIR SHAMPOOED? IN SALON** **AT HOME**

**WHICH HAIR PRODUCTS DO YOU USE:**

**HAVE YOU EVER HAD A PERMANENT RELAXER?** **[ ]  YES** **[ ]  NO**

**IF SO, WHEN WAS YOUR LAST ONE?**

**HAVE YOU EVER HAD PERMANENT COLOR?** **[ ]  YES** **[ ]  NO**

**IF SO, WHEN WAS YOUR LAST ONE?**

**DO YOU CURRENTLY HAVE A CHEMICAL TREATMENT IN YOUR HAIR?** **[ ]  YES** **[ ]  NO**

**TYPE:** **[ ]  PERMANENT RELAXER** **[ ]  PERMANENT COLOR**

**HOW OFTEN IS YOUR HAIR CHEMICALLY TREATED?**

**IF CHEMICALLY TREATED, DOES YOUR SCALP:** **[ ]  BURN** **[ ]  TINGLE □ ITCH**

**DO YOU HAVE OILY SKIN OR SCALP?** **[ ]  YES** **[ ]  NO**

**IS YOUR SCALP FLAKY, CRUSTY, INFLAMMED, OR ITCHY?** **[ ]  YES** **[ ]  NO**

**IF YOU SCRATCH YOUR SCALP, DO SMALL PATCHES OF SCALE WITH HAIRS ATTACHED COME OUT?**

**[ ]  YES** **[ ]  NO**

**HAS YOUR SCALP BEEN INJURED? [ ]  YES [ ]  NO**

**HAVE YOU BEEN DIAGNOSED WITH A SCALP FUNGUS? [ ]  YES [ ]  NO**

**IF YES, PLEASE EXPLAIN**

**WHEN STYLING YOUR HAIR, DO YOU USE: □ BLOW DRYER □ FLAT IRON □ ROLLERS**

**HAVE YOU BEEN EXPERIENCING ANY HAIR SHEDDING? [ ]  YES [ ]  NO**

**IF YES, HOW LONG?**

**DOES YOUR HAIR BREAK WHEN YOU COMB IT? [ ]  YES [ ]  NO**

**DO YOU SLEEP ON A: □ COTTON PILLOW CASE □ SATIN PILLOW CASE**

**HAVE YOU EVER HAD EXTENSIONS OR A WEAVE? [ ]  YES [ ]  NO**

**IF YES, WHAT TYPE AND WHEN?**

**DO YOU HAVE ANY ALLERGIES?**

**DO YOU TAKE VITAMIN OR MINERAL SUPPLEMENTS? [ ]  YES [ ]  NO**

**IF YES, WHICH ONES?**

**HOW MANY GLASSES OF WATER DO YOU DRINK PER DAY?**

**DO YOU HAVE A THYROID IMBALANCE? [ ]  YES [ ]  NO**

**DO YOU CRAVE SUGAR CONSTANTLY? [ ]  YES [ ]  NO**

**HAVE YOU BEEN DIAGNOSED AS A DIABETIC? [ ]  YES [ ]  NO**

**HAVE YOU BEEN DIAGNOSED AS ANEMIC? [ ]  YES [ ]  NO NO**

**HAVE YOU GAINED OR LOST MORE THAN 1SLBS RECENTLY? [ ]  YES [ ]  NO**

**ARE YOU PRESENTLY, OR HAVE YOU BEEN ON A WEIGHT LOSS DIET? [ ]  YES [ ]  NO**

**DO YOU EXPERIENCE IRREGULAR OR INFREQUENT BOWEL MOVEMENTS? [ ]  YES [ ]  NO**

**HAVE YOU EXPERIENCED EXCESSIVE EMOTIONAL STRESS? [ ]  YES [ ]  NO**

**DO YOU SUFFER FROM ACNE? [ ]  YES [ ]  NO**

**DO YOU EXPERIENCE FREQUENT ILLNESS? [ ]  YES [ ]  NO**

**DO YOU HAVE POOR BLOOD CIRCULATION? [ ]  YES [ ]  NO**

**HAVE YOU RECENTLY GIVEN BIRTH OR HAD A RECENT SURGERY? [ ]  YES [ ]  NO**

**IF YES, WHEN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOW MANY CHILDREN DO YOU HAVE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU HAVE METAL IMPLANTS? [ ]  YES [ ]  NO**

**DO YOU HAVE A PACEMAKER? [ ]  YES [ ]  NO**

**DO YOU HAVE A HEART CONDITION? [ ]  YES [ ]  NO**

**HAVE YOU BEEN DIAGNOSED WITH EPILEPSY? [ ]  YES [ ]  NO**

**FOR WOMEN, ARE YOU MENOPAUSAL? [ ]  YES [ ]  NO**

**DO YOU HAVE EXCESSIVE FACIAL HAIR? [ ]  YES [ ]  NO**

**FOR MEN, DO YOU HAVE EXCESSIVE BODY HAIR? [ ]  YES [ ]  NO**