**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**