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

Responses to the following data is used to help the stylist provide the best care for your hair and scalp while avoiding any products and/or services that may be not be suitable for you based on personal circumstances. Please complete according to your level of comfort.

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 15 LBS 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**