# SCALP CONDITION INTAKE FORM

For clients with eczema, psoriasis, seborrheic dermatitis, or other scalp concerns.

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## Client Information

Full Name: ______________________________

Date of Birth: ___________________

Phone Number: ___________________

Email Address: ___________________

Address: ______________________________

Emergency Contact: ___________________

Referred by: ______________________________

## Primary Concern

What brings you in today?

Eczema Psoriasis Seborrheic dermatitis Folliculitis
Dandruff/flaking Itching/burning Redness/irritation
Other: ________________________________

When did you first notice the issue? ___________________

Has it been: Constant Intermittent Seasonal

Has it spread or changed over time? Yes No
If yes, describe: ______________________________

Have you been formally diagnosed by a doctor or dermatologist? Yes No

## Symptoms & Severity

Please check all that apply:

- Flaking or scaling
- Itching or burning sensation
- Oozing or crusting
- Redness or inflammation
- Tenderness or pain
- Pus-filled bumps or sores
- Hair shedding or thinning
- Greasy buildup or odor

On a scale of 1–10, how severe are your symptoms? ___ /10

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What areas of the scalp are affected?

Frontal   Crown   Nape   Behind ears   All over   Other: __________

**Triggers & Patterns**

Have you noticed any triggers?

- Stress
- Weather change
- Hair or scalp products
- Hormonal changes
- Certain foods or drinks
- Lack of sleep
- Medications
- Chemical or color treatments
- Other: ______________________________

Are symptoms worse during:

Winter   Summer   After washing   After sweating/exercise

How often do you shampoo? ___________ times per week

Do you use medicated or prescription shampoos?   Yes   No

If yes, which ones? ________________________________________________

**Medical History**

Please check all that apply:

- Eczema (body or scalp)
- Psoriasis
- Seborrheic dermatitis
- Allergies or sensitivities
- Fungal infections (ringworm/tinea capitis)
- Autoimmune conditions
- Thyroid imbalance
- Hormonal disorders
- Anxiety or high stress
- Other chronic conditions: ______________________________

Are you currently under a physician's care?   Yes   No

If yes, for what conditions? ______________________________________________________

Current medications: ______________________________________________________________

Topical creams, ointments, or prescriptions for scalp: ___________________________

______________________________________________________________________________________

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## Lifestyle & Habits

Diet type: Balanced Vegetarian/Vegan High sugar High dairy Processed

Water intake: __________ cups/day

Sleep quality: Good Fair Poor

Stress level (1–10): _______

Do you smoke or vape? Yes No

Do you consume alcohol? Yes No

## Hair & Scalp Care Routine

What shampoo/conditioner are you currently using? ______________________

Do you use:

Oils Leave-in conditioners Dry shampoo Hair color Relaxer
Extensions Heat tools

How often do you apply new products? ____________________________

Do you experience scalp sensitivity after using hair products? Yes No
If yes, specify which products: ____________________________

## Previous Treatments

Have you tried any of the following for your scalp condition?

- Medicated shampoo
- Corticosteroid cream/lotion
- Oral medication
- Antifungal treatments
- Natural/herbal remedies
- Light therapy
- Scalp detox or exfoliation treatments
- Other: ____________________________

Were they effective? ____________________________________________

## Family & Genetic Background

Any family history of scalp or skin disorders? Yes No
If yes, which? ______________________________________________________________

Any family history of hair loss or autoimmune disorders? Yes No

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**Client Goals & Concerns**

What are your main goals for this consultation?

What outcomes would you like to achieve with treatment?

**Consent & Acknowledgment**

I understand that this Trichology consultation is for the purpose of evaluating my scalp and hair condition. It is not a medical diagnosis or treatment and does not replace advice from a licensed medical professional.

Client Signature: ______________________________________________

Date: ______________________________________________

## Practitioner Notes: