



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: