KSS Hair Care Client Intake Form

Department: Hair and Barber

Gender

- [ ] Female
- [ ] Male

Date *

Month Day Year

Name *

First Name Last Name

Date of Birth *

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code Country

Phone Number *

Area Code Phone Number

E-mail *

example@example.com

How did you hear about me? *

- [ ] Website / Online Search
- [ ] Yelp
- [ ] Facebook
- [ ] Referral
- [ ] Other

If Referral, please list name

If Other, please let me know

Emergency Contact (EC)

EC Phone Number

Area Code Phone Number

Your Hair

What is your current hair length? *

- ☐ Short
- ☐ Ear Length
- ☐ Shoulder Length
- ☐ Mid-back Length
- ☐ Lower-back + Length
- ☐ Bald

Is your hair naturally curly? *

- ☐ Yes
- ☐ No

How would you describe your scalp? *

- ☐ Dry
- ☐ Normal
- ☐ Oily

How would you describe the current condition of your hair? *

- ☐ Healthy
- ☐ Slightly Damaged
- ☐ Dry/Damaged

How often do you shampoo your hair? Select one *

- ☐ Daily
- ☐ Weekly
- ☐ Bi-weekly
- ☐ Monthly

How often do you condition your hair? Select one *

- [ ] Daily
- [ ] Weekly
- [ ] Bi-weekly
- [ ] Monthly

How often do you apply a deep conditioner on your hair? Select one *

- ☐ Daily
- ☐ Weekly
- ☐ Bi-weekly
- ☐ As Needed
- ☐ Never

How would you describe the curl pattern of your hair? Select one *

- ☐ Straight
- ☐ Wavy
- ☐ Textured
- ☐ Don't Know

How would you describe the density of your hair? Select one *

- ☐ Fine
- ☐ Medium
- ☐ Thick
- ☐ Don't Know

Do you have now, or have had in the past, any problems with hair loss? *

- ☐ Yes
- ☐ No

Are you currently taking any medication that has side effects that can cause hair thinning and/or hair loss? If so, which one(s)?

What are your long-term hair goals? Select one

- [ ] More Length
- [ ] More Moisture
- [ ] Permanent Color
- [ ] Manageability
- [ ]

Is there anything you need to improve your current method of hair care? Select one

- [ ] Daily Regimen
- [ ] Hair Products
- [ ] Eating Habits
- [ ] Water Intake
- [ ]

Date of your last visit to a hairstylist or barber:

For Males Only: What is your current shaving system?

- [ ] Razor/Wet Shave
- [ ] Electric
- [ ]

For Males Only: Do you experience irritation from shaving?

- ☐ Yes
- ☐ No

Your Health

Are you currently taking medications? If so, please list:

Have you experienced any of these health conditions in the past or present? *

- ☐ Arthritis
- ☐ Asthma
- ☐ Auto-Immune Disorders
- ☐ Cancer / Systemic Disease
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy / Seizure Disorder
- ☐ Headaches / Migraines
- ☐ Head Lice
- ☐ Heart problem
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hormone Imbalance
- ☐ Lupus
- ☐ Psoriasis
- ☐ Scleroderma
- ☐ Sickle Cell Anemia
- ☐ Other
- ☐ None

If you checked yes to any of these please provide further information. If not mark N/A *

Are you pregnant? *

- [ ] Yes
- [ ] No
- [ ] No, not Applicable

Please list any known allergies including food, medicines, scents, plants, etc.:

Read and Accept: *

☐ By signing below, you attest that you have provided accurate and current information on this form and answered all medical and health-related questions truthfully and completely. Your signature also certifies that you understand that Karline's Salon and Spa reserves the right to deny service to any client due to a health condition he or she has that may pose a potential risk to practitioners or other clients, including those that pose a risk of potential contamination to service areas. Furthermore, signing below verifies that you understand that you are responsible for informing Karline's Salon and Spa and/or its stylists of ANY and ALL changes to your health condition as regards any question on this form or any potential public health risk that may arise from any change in your health condition. You acknowledge and accept that withholding information or providing misinformation may result in contraindications and/or irritation to the hair and scalp from treatments received. The treatments you receive here are voluntary and you release this hair care professional and Karline's Salon and Spa from liability and you assume full responsibility thereof.

Signature

Consent to Treatment of Minor: *By signature below, I also hereby authorize Karline's Salon and Spa to administer service(s) to my child or dependent as they deem necessary.*

Signature

Reservation & Cancellation Policy for all current and future appointments: Please do not forget to confirm your appointment. In the event of no shows, cancellations received less than 24 hours prior to appointment Tues-Fri; less than 48 hours prior to a Saturday, Sunday, or private appointment, a $25.00 cancellation fee will incur. *

☐ I understand the reservation and cancellation policies at Karline's Salon and Spa and consent to my credit card on file being charged if I fail to show for my appointment or to give 24 hour notice for appointments scheduled Tuesday through Friday and/or 48 hours notice for Saturday or private appointments. In the event a credit card is not on file, I agree to the addition of a $25.00 fee assessment on my next appointment.

Submit