



**ANTECH HAIR LABS**  
 1240 Bay Street, Suite 200  
 Toronto, Ontario, M5R 2A7  
 Toll Free: 1-877-798-HAIR (4247)

**Name:**  
**Address:**  
**City:**  
**Occupation:**  
**Daytime#:**

**Postal Code:**  
**Referred By:**  
**Evening #:**

Please print and fill out this form

**Hair loss First Noticed:**

**Shampooing Frequency:**                    1XW                    2XW                    3XW

**Do You Use:**                                    Gel?                    Mousse?                    Hairspray?

**Other Hair Preparations Used:** Dyes                    Perms                    Bleach                    Henna                    Other (specify)



**DO YOU SWIM REGULARLY IN CHLORINATED WATER?** Yes or No

**DOES YOUR SCALP ITCH?** Yes or No

**ANY SORENESS OR TENDERNESS?** Yes or No

**IS YOUR FATHER LOSING HAIR?** Yes or No

**IS YOUR MOTHER LOSING HAIR?** Yes or No

**DO YOU NOTICE DANDRUFF?** Yes or No

**DO YOU SMOKE?** Yes or No

**LAST PHYSICAL OR MEDICAL CHECK UP:** \_\_\_\_\_

**DO YOU SUFFER FROM ANY DIAGNOSED ILLNESS?** Yes or No If yes, what? \_\_\_\_\_

**ARE YOU TAKING ANY MEDICATIONS?** (Please indicate which ones)

\_\_\_\_\_

**PLEASE RATE YOUR STRESS LEVEL ON A SCALE OF 1 to 10:**                    /10

**BRIEF NUTRITIONAL EVALUATION**

1. Number of times per week that you eat snacks or meals at Fast Foods  
 0-1    2-4    5-7    8-10    11+
2. Number of soft drinks consumed per week  
 0-2    3-5    6-8    8-10    11+
3. Number of meals with green leafy vegetables per week  
 5-7    8-10    11-14    15+    less than 4
4. Number of meals with beef, pork, chicken, and fish eaten per week  
 0-3    4-7    8-10    11-13    15+
5. Cups of coffee per day    0-1    2-4    3-5    6-8    9
6. Do you take vitamin or mineral supplements? Which ones? \_\_\_\_\_

**IN MY OPINION THE INFORMATION I HAVE FILLED OUT IS CORRECT TO THE BEST OF MY KNOWLEDGE AND I UNDERSTAND THERE IS NO OBLIGATION.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_