Client Intake Form

CLIENT INFORMATION

NAME: .....

ADDRESS: .....

CITY: .....

PHONE #: .....

EMAIL: .....

BIRTH MONTH: .....

EMERGENCY CONTACT & PHONE #: .....

HAIR HISTORY

- ARE YOU CURRENTLY ON ANY MEDICATION THAT IS CAUSING SIDE EFFECTS WITH YOUR HAIR?

- WHAT ARE YOUR CURRENT HAIR GOALS?

thicker longer low maintenance healthier brighter texture change

- IF YOU COULD CHANGE ANYTHING ABOUT YOUR HAIR RIGHT NOW WHAT WOULD IT BE?

- WHAT DO YOU LOVE THE MOST ABOUT YOUR HAIR?

- WHAT IS YOUR DAILY HAIR ROUTINE?

CHEMICAL SERVICES

- HAVE YOU HAD ANY REACTIONS TO COLOUR OR PERMING/TEXTURIZING SERVICES IN THE PAST?
- HAVE YOU ALWAYS GONE TO A PROFESSIONAL FOR YOUR CHEMICAL SERVICES?
- DO YOU HAVE ANY KNOWN ALLERGIES TO PROFESSIONAL COLOURS OR PERMS/TEXTURIZERS?
- IS THERE A POSSIBILITY THAT YOU COULD BE PREGNANT?
- WHAT PRODUCTS ARE YOU CURRENTLY USING?

I have read the above information and have given an accurate account of all the questions. If I have any concerns I will address the stylist before our session begins. I give my stylist full permission to perform the requested chemical services. I have had the chance to ask any questions that I might have. I will not hold the establishment nor the stylist accountable for any liabilities that may result from this service. I understand that my stylist will take every precaution to ensure the integrity of my hair and/or eliminate any risk involved with this chemical service.

client name client signature date

stylist name date

NATURAL LEVEL: PERCENTAGE OF GREY:

DESIRED LEVEL: NOTES:

CHEMICAL SERVICES

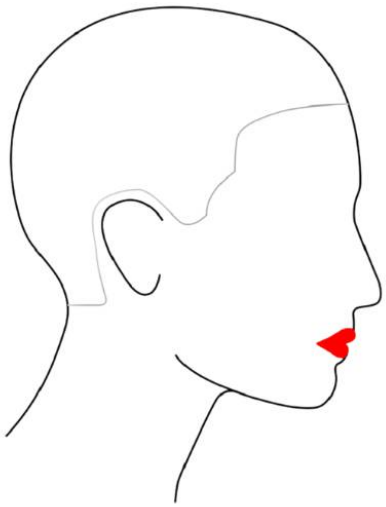
DATE	FORMULA	PROCESSING TIME/NOTES	COST

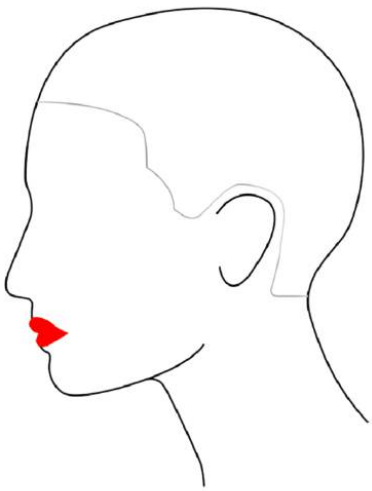
CHEMICAL SERVICES

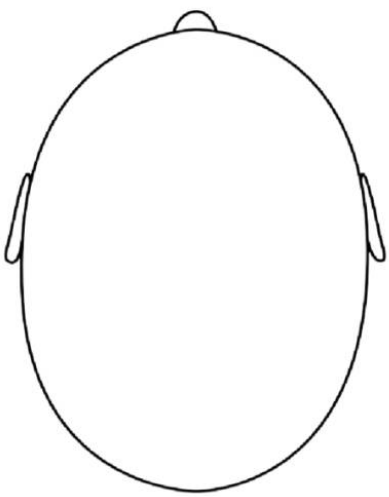
ALL TANGLED SALON
Confident. Beautiful. Unique.

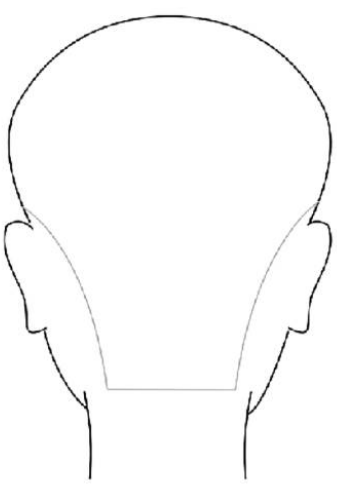
DATE	FORMULA	PROCESSING TIME/NOTES	COST

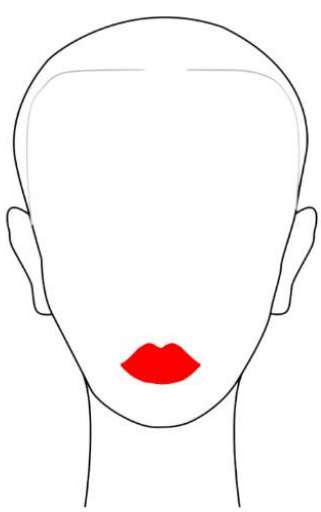
GUEST NAME: ..... DATE: .....











WWW.ALLTANGLEDSALON.COM