Scalp Spa Client Intake Form

Name: _____
Phone: _____
Email: _____

How would you describe your scalp?
☐ Dry ☐ Oily ☐ Sensitive ☐ Flaky ☐ Itchy ☐ Balanced

How would you describe your hair?
☐ Fine ☐ Medium ☐ Coarse
☐ Straight ☐ Wavy ☐ Curly ☐ Coily

Do you experience shedding or thinning?
☐ Yes ☐ No
If yes, how often? (1 = rarely, 5 = often): 1 2 3 4 5

Any scalp concerns? (itching, flakes, tightness, etc.)
Rate frequency: 1 2 3 4 5

Any diagnosed scalp conditions?
☐ No ☐ Psoriasis ☐ Eczema ☐ Dermatitis ☐ Other:

Had a scalp treatment before?
☐ Yes ☐ No
If yes, is there anything you'd change?

How often do you shampoo?
☐ Daily ☐ Every 2–3 days ☐ Weekly

Do you use dry shampoo?
☐ Never ☐ Occasionally ☐ Often

Are you using hair growth treatments?
☐ Yes ☐ No

Stress level (circle one):
1 2 3 4 5

Do you frequently wear hats, helmets, or head coverings?
☐ Yes ☐ No

Allergies/sensitivities to oils, fragrance, skincare ingredients?
☐ Yes ☐ No
If yes: _____

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Are you taking any medications affecting skin/hair?
☐ Yes ☐ No

Recent chemical services (last 6–8 weeks)?
☐ Color ☐ Bleach ☐ Perm/Relaxer ☐ Keratin ☐ None

Any scalp tenderness or open areas today?
☐ Yes ☐ No

Pressure preference:
☐ Light ☐ Medium ☐ Firm

During your session, would you prefer:
☐ A silent, meditative experience
☐ Occasional light conversation
☐ A mix of both
☐ No preference

Would you like extra relaxation with a neck and arm massage?
☐ Yes
☐ No

Are you wearing any makeup today?
☐ Yes
☐ No