



# MICROLOC

## Client Intake & Consultation Form

"PROVIDING THE HAIR THAT YOU WILL TREASURE"

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### CLIENT INFORMATION

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

Preferred Method of Contact:

Phone Call     Text Message     Email

### SERVICE REQUESTED

Microloc Consultation     Microloc Grooming

New Microloc Installation     Microloc Color Service

Microloc Retightening     Microloc Removal

Microloc Repair     Other: \_\_\_\_\_

Microloc Reattachment

Microloc Extensions

### HAIR HISTORY

**Current Hair Length:**

TWA (Teeny Weeny Afro)     Ear Length     Neck Length

Shoulder Length     Mid-Back     Waist Length     Longer

**How would you describe your hair texture?**

Fine     Medium     Coarse

**Have you previously worn locs?**     Yes     No

If yes, please explain: \_\_\_\_\_

**Have you ever had Microlocs, Sisterlocks, Interlocks, Traditional Locs, Braids, or Extensions?**     Yes     No

Please explain: \_\_\_\_\_

### HAIR LOSS & SCALP HEALTH ASSESSMENT

**Have you experienced any of the following?** (Check all that apply)

Excessive Shedding     Hair Thinning     Bald Spots

Receding Hairline     Alopecia     Traction Alopecia

Postpartum Hair Loss     Medical Hair Loss     Scalp Psoriasis

Seborrheic Dermatitis     Eczema     Scalp Irritation

Scalp Tenderness     Excessive Dandruff     None

**Please describe any scalp concerns:**

\_\_\_\_\_

### MEDICAL HISTORY

**Have you been diagnosed with any medical conditions that may affect your hair or scalp?** (Check all that apply)

Thyroid Disorder     Lupus     Diabetes

PCOS     Cancer     Autoimmune Disorder

Anemia     Hormonal Imbalance     Other

Please explain: \_\_\_\_\_

**Are you currently under the care of a physician, dermatologist, or trichologist?**     Yes     No

**Are you currently taking medications that may impact hair growth?**

Yes     No

If yes, please list: \_\_\_\_\_

### HAIR CARE ROUTINE

**How often do you shampoo your hair?**

Weekly     Every 2 Weeks     Every 3 Weeks

Monthly     Other: \_\_\_\_\_

**Current products used:** \_\_\_\_\_

**Do you use:** (Check all that apply)

Oils     Butters     Leave-In Conditioners

Hair Growth Products     Edge Control     None

### MICROLOC GOALS

**What inspired you to start your Microloc journey?**

\_\_\_\_\_

**What are your expectations for your Microlocs?**

\_\_\_\_\_

**Desired Size:**

Extra Small     Small     Medium     Custom

**Desired Parting Pattern:**

Traditional Grid     Brick Layer     Custom

**Preferred Maintenance Schedule:**

4 Weeks     6 Weeks     8 Weeks     Other \_\_\_\_\_

### LIFESTYLE ASSESSMENT

**Do you participate in:** (Check all that apply)

Swimming     Heavy Exercise     Frequent Travel

Professional Modeling     Public Speaking     Other \_\_\_\_\_

**Do you wear wigs, hats, or protective styles regularly?**     Yes     No

If yes, please explain: \_\_\_\_\_

### CONSULTATION PHOTOS (FOR OFFICE USE)

Front     Left Side     Right Side     Back

Crown     Hairline     Areas of Concern

### CONSULTANT NOTES (FOR OFFICE USE ONLY)

Hair Density:     Low     Medium     High

Hair Texture:     Fine     Medium     Coarse

Estimated Loc Count: \_\_\_\_\_

Recommended Size: \_\_\_\_\_

Recommended Maintenance Schedule: \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Consultant Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### CLIENT ACKNOWLEDGMENTS

Please initial each statement.

\_\_\_\_\_ I understand that Microlocs are a long-term commitment.

\_\_\_\_\_ I understand that my hair will go through stages including budding, frizzing, and maturation.

\_\_\_\_\_ I understand that results vary based on hair texture, density, health, and maintenance.

\_\_\_\_\_ I understand that regular maintenance is necessary for healthy Microlocs.

\_\_\_\_\_ I understand that failure to follow aftercare instructions may affect the appearance and health of my Microlocs.

\_\_\_\_\_ I have disclosed all known medical conditions and medications that may affect my hair and scalp.

I authorize Treasured Locs and Tips to photograph my hair for documentation, educational purposes, and marketing materials.

Yes     No

### SERVICE POLICIES

**DEPOSITS**  
All deposits are non-refundable and non-transferable.

**RESCHEDULING**  
Appointments must be rescheduled at least 24 hours in advance.

**LATE ARRIVALS**  
Clients arriving more than 15 minutes late may need to be rescheduled.

**REFUND POLICY**  
Due to the nature of professional hair services, all Microloc services are non-refundable.

### CLIENT SIGNATURE

I certify that the information provided is accurate and complete to the best of my knowledge.

Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_