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Date: ___ / ___ / ___

CONFIDENTIAL QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire. The information will be treated in confidence and will be helpful during consultation to give you our best advice and service.

Name _____
 First Name Middle Name Family Name

Address _____
 _____ Postcode _____

Tel (H) _____ (W) _____ (M) _____ Email _____

Age _____ DOB _____ / _____ 19 _____ Occupation _____ Married / Single

How did you hear about IHRB? (Please name source): _____

What is your favorite? Sport _____ Are you planning a family? _____

Which of the following hair and scalp problems do you wish to treat?

- Hair Loss
- Dandruff
- Itchy Scalp
- Oily / Dry Hair

How long ago did you first notice excessive hair loss? _____ Weeks / Years / Months

What previous treatment have you had for the problem? _____

What results were achieved? Excellent Good Unsatisfactory Totally Ineffective

Other (please specify) _____

What results do you wish to achieve? _____

Which of the following appeals to you?

- I want to see and feel good about the results
- I want others to comment on the improvement

Which of the following was the most important factor in motivating you to take action for your problem?

- I am concerned about my appearance and want a solution
- I want to increase my confidence and self esteem
- I want to look younger
- My 'family doctor' / a friend / family member urged me to seek advice
- Other (please specify) _____

Has your spouse / partner.....

- Encouraged you to do something about it
- Says it does not matter
- Made no comment

Are there any comments you wish to make regarding your 'hair loss' and scalp problems that we should be aware of? _____

Thank you for your assistance.

Signature: _____

VARIOUS STAGES OF MALE PATTERN BALDNESS AND OUR RECOMMENDED OPTIONS



Medical Treatment

Non-Surgical Hair Additions

Surgical Hair Replacement

Roughly sketch you area of hair loss

