Lice Clinics OF AMERICA®

CLIENT RECORD

① ADULT CLIENT OR PARENT/GUARDIAN OF PATIENT

Date: _____

First: _____ Last: _____ Phone: _____

Street Address: _____ City, State: _____ Zip: _____

E-mail Address: _____ Number of people in the household: _____

How did you hear about us? (check all that apply) ☐ Google ☐ Facebook ☐ Friend ☐ TV/News

☐ School ☐ Doctor ☐ Radio ☐ Yelp ☐ Other (please list): _____

② CLIENT (COMPLETE IF DIFFERENT THAN ABOVE)

☐ Resides full-time at address above

First: _____ Last: _____ Gender: ☐ M ☐ F

Date of Birth: _____ Age: _____ Pediatrician _____

Relation to person completing form (child, spouse, etc.) _____ School: _____ Grade: _____

③ SYMPTOMS (CHECK ALL THAT APPLY)

☐ Itching ☐ Scalp Irritation ☐ Embarrassed ☐ Anxiety ☐ Fatigue/Not Sleeping Well

☐ Abnormal Scalp Sensation (tingling, other) ☐ None ☐ Other (list) _____

Duration symptoms have lasted _____ days/weeks/months

PREVIOUS TREATMENT?

☐ Prescription: which one _____ how often _____ date last used _____

☐ Drug Store Product: which one _____ how often _____ date last used _____

☐ Combing: how often _____ date last performed _____

☐ Home remedy or homeopathic (list): _____

☐ Other Services: what _____ how often _____ date last performed _____

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NAME OF TECHNICIAN COMPLETING THIS SECTION _____

PHYSICAL FINDINGS: Screen: Mild Moderate Severe

Nits: ☐ Yes ☐ No Dead Lice: ☐ Yes ☐ No Redness (where): ☐ Yes ☐ No

Scratches: ☐ Yes ☐ No Open Sores: ☐ Yes ☐ No Hatched Lice: ☐ Yes ☐ No

Flaking: ☐ Yes ☐ No Where: _____

GENERAL OBSERVATIONS (tired, embarassed, other): _____

SCREENING RESULT: ☐ Positive ☐ Negative TREATMENT NECESSARY: ☐ Yes ☐ No

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TREATMENT PERFORMED: ☐ None ☐ AirAllé® Signature ☐ AirAllé® Express ☐ Comb-Out ☐ Topical Products/Applied

TOPICAL PRODUCT USED: ☐ None ☐ Super Gel ☐ Active Rinse 50/50 ☐ 100% Dimethicone ☐ Other: _____

INSURANCE (DOES NOT APPLY FOR MEDICAID, MEDICARE OR CHIP):

Form provided to customer (date): _____ Insurance Response (date): _____

Insurance Company Name: _____

Details: _____

FINAL CHECK-LIST:

Were all family members at the appointment? ☐ Yes ☐ No If no, who was not there: _____

Were all family members present checked and treated as needed? ☐ Yes ☐ No

Did all cleared family members without an active infestation receive topical product application? ☐ Yes ☐ No

Does this family qualify for the day guarantee? ☐ Yes ☐ No Notes: _____

_____

④ TREATMENT GUARANTEE

CLIENT QUALIFIES FOR TREATMENT GUARANTEE

I acknowledge that the day guarantee is an optional guarantee. All immediate family members of the household, living either part-time or full-time with the person receiving an AirAllé treatment must be screened within 24-hours by a certified Lice Clinics of America technician, otherwise this guarantee is not valid.

Print Name of Client

Signature of Adult Client or Parent/Guardian Date

CLIENT DOES NOT QUALIFY FOR TREATMENT GUARANTEE

I understand that my family will not receive the Lice Clinics of America day guarantee.

Print Name of Client

Signature of Adult Client or Parent/Guardian Date

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