

# Hair Relaxer

The Legal Leads 

**\*Intake Forms Are Fully Customizable To Your Firm's Need\***

## CONTACT INFORMATION

Client Full Name:

Date Of Birth:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

Gender:

M/F

Address:

Phone:

E-mail:

Best Contact Time:

Emergency Contact Name:

Emergency Contact Phone:

Emergency Contact Relationship:

## LEAD INFO

Calling For:

Name of caller (if calling for someone else):

Caller's relationship to injured person:

List of hair straightening product (s) you have used:

Do you know if product contains Formaldehyde or Phthalates chemicals?

Yes

No

Indicate if product was used in a Salon or at home:

Salon

Home

When 1st exposed:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	M	M	Y	Y	Y	Y	Y

When last exposed:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	M	M	Y	Y	Y	Y	Y

How often have you used straightening products within a 12-month period?

Type of Injury:

Age at time of diagnosis:

Date diagnosed:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	M	M	Y	Y	Y	Y	Y

City Diagnosed:

State Diagnosed:

Where diagnosed name:

Where diagnosed phone:

Where diagnosed address:

Treatment Date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	M	M	Y	Y	Y	Y	Y

Name of treatment facility:

Address of treatment facility:

Phone number of treatment facility:

Call recording link:

Notes: