AROMATHERAPY CONSULTATION Date_____

Name_____

Address _____

City, State, Zip _____

Phone: home_____ Cell_____

Email _____

For notifications, reminders, newsletters, promotions

Birth date_____ Age _____Marital status: M/ S/ W/ D

Employer _____

Occupation _____

Emergency Contact _____

Phones: Home_____ cell_____

Occupation _____

Primary Health care Provider

Name _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Health History/Information

Height _____weight_____

Have you ever been treated by a holistic practitioner?

_____Type_____

What were you treated for/ what were the results? Did it help?_____

When was your last medical exam? What were the results?

_____

List all conditions <u>currently</u> monitored by a health care professional

_____

_____

_____

List and explain, include dates and treatment received

Surgeries _____

_____

Major Illnesses_____

_____

Accidents _____

_____

How was your recovery? Complicated, or as expected.

_____

Date and nature of any traumatic experiences you have had, (e.g. divorce, loss, job, change of residence, injury, death in family, etc.)

_____

_____

List **<u>all</u>** medications, including supplements, pain relievers and herbal remedies_____

_____

_____

What type of work do you do? _____

Do you enjoy it? _____

If no, what type of work would you like to do?

_____

What 2 emotions seem dominant in your life? _____

_____

What are the major stresses of your life? _____

_____

How do you cope with stress? _____

_____

Do you feel you carry your stress in a particular area of your body?

_____Where? _____

_____

Rate your stress 1= mild 10= Overwhelming

	1-10	Source
Work		
Family/home		
Significant relationship		
Other		

How would you describe your family/home life? (e.g. Stable, chaotic, hectic, enjoyable, stressful) _____

_____

How would you describe your relationship with your significant other? _____

_____

How do you feel about your life in general? (Fulfilled, something's missing, etc.) _____

_____

Do you feel fatigued or exhausted? Do you know the source?

_____

Describe your energy level (Low, average, moderate, high, manic)

_____

_____

When do you feel energetic? (Morning, afternoon, evening, night, day, week, month) _____

_____

When do you feel you have low energy? (Morning, afternoon, evening, night, day, week, month) _____

_____

How comfortable are you expressing yourself?(Not at all, somewhat comfortable, no problem expressing myself) _____

_____

How do you cope with (your own) illnesses? _____

_____

General

Current	Past	
☐	☐	Headaches _____
☐	☐	Pain _____
☐	☐	Infection _____
☐	☐	Fever _____
☐	☐	Sinus _____
☐	☐	Other _____

Habits

☐	☐	Tobacco _____/day
☐	☐	Alcohol _____
☐	☐	Drugs _____
☐	☐	Coffee/tea _____
☐	☐	Soda _____oz/day

Skin

☐	☐	Rashes
☐	☐	Athlete's foot
☐	☐	Nail fungus
☐	☐	Warts/skin lesions
☐	☐	Acne/boils

Allergies

Current	Past	
☐	☐	**Nuts/food _____**
☐	☐	Detergents/ latex
☐	☐	Scents/oils/lotions
☐	☐	Other _____

Muscles and Joints

Current	Past	
☐	☐	rheumatoid arthritis
☐	☐	Osteoarthritis
☐	☐	Osteoporosis
☐	☐	Scoliosis
☐	☐	Broken bones
☐	☐	Spinal problems
☐	☐	Disk problems
☐	☐	TMJ/jaw pain
☐	☐	Spasms, cramps
☐	☐	Sprains, strains
☐	☐	Tendonitis, bursitis
☐	☐	Stiff/painful joints
☐	☐	Weak/sore muscles
☐	☐	Neck/shoulder/arm pain
☐	☐	Low back/hip/leg pain
☐	☐	Other _____

Nervous system

Current	Past	
☐	☐	Head injury, concussion
☐	☐	Dizziness/ringing in ears
☐	☐	Loss of memory confusion
☐	☐	Numbness tingling

Where?_____

☐	☐	Sciatica, shooting pain
☐	☐	Chronic pain
☐	☐	Depression
☐	☐	Fibromyalgia
☐	☐	Shingles/herpes
☐	☐	Other _____

Respiratory/Cardiovascular

Current	Past	
☐	☐	**High blood pressure**
☐	☐	**Low blood pressure**
☐	☐	Heart disease
☐	☐	Blood clots
☐	☐	Stroke
☐	☐	Lymphedema
☐	☐	Irregular heart beat
☐	☐	Poor circulation
☐	☐	Swollen ankles
☐	☐	Varicose veins
☐	☐	Chest pain,
☐	☐	shortness of breath, asthma
☐	☐	Other _____

Digestive/Elimination system

Current	Past	
☐	☐	Bowel dysfunction
☐	☐	Gas, bloating
☐	☐	Bladder/kidney dysfunction
☐	☐	Constipation
☐	☐	Abdominal Pain
☐	☐	Other _____

Endocrine system

Current	Past	
☐	☐	Thyroid dysfunction
☐	☐	Diabetes
☐	☐	Lupus
☐	☐	Other _____

Reproductive system

Current	Past	
☐	☐	Pregnancy
☐	☐	Painful, emotional menses
☐	☐	Menopause
☐	☐	Fibrotic cysts
☐	☐	Other _____

Cancer/Tumors

Current	Past	
☐	☐	Benign
☐	☐	Malignant
☐	☐	**Estrogen based**
☐	☐	Other _____

For Women Only:

_____ vaginal infection with discharge _____ breast lumps _____ genital burning,_____ yeast infection _____ irregular cycles _____ positive PAP_____ urinary tract infection _____ menstrual cramps _____ hemorrhoids_____ ovarian cyst_____ infertility _____ anal fissures_____ **Estrogen based cancer/malignancy** _____ pelvic inflammatory disease

Are you trying to conceive? _____ Are you pregnant now? _____What kind of birth control do you use?

Number of Pregnancies_____ Births _____

Terminations/miscarriages_____

Describe our physical, mental, emotional health while pregnant. (i.e. physical difficulties, lack of emotional support)

_____

_____

Please list any PMS/menopause symptoms?_____

_____

For Men Only:

_____ prostatitis ____ burning urination _____urinary incontinence_____ nocturnal emission _____ pre-mature ejaculation _____ impotence_____ Jock Itch _____Infertility _____

Product Preference

Which aromas are you attracted to (E.g.: floral, citrus, camphor, etc.)? _____

Which aromas do you avoid? _____

Please number the following in order of preference using the numbers from 1 to 9. If there is a product you absolutely do not want please enter an "X".

Room Spray _____Bath Salts_____ Bath Oil_____ Salt/Sugar Scrub_____ Inhalant _____

Massage Cream_____ Massage Oil _____ Moisturizer_____ Face Spray_____ Masques_____

Additional comments

I know and understand the following:

- Aromatherapy is a complementary therapy is not to be thought of as a cure for ailments, that aromatherapy is an alternative treatment used only to help alleviate symptoms of ailments and should not be used to replace your current doctor's advice. It is meant as an addition to your current healthcare providers care.
- Aromatherapy is not a substitute for medical treatment or medications and it is recommended that I concurrently work with my primary healthcare provider for any conditions I have.
- That the aromatherapist does not diagnose illness/disease or any physical or mental disorder, nor do they prescribe medical treatment or medications.
- That the treatment is given for the well-being of my body and mind.
- By signing below I hereby state that to the best of my knowledge this intake form contains true, complete and accurate information. The undersigned hereby releases and agrees to indemnify and hold harmless Balanced By Touch and Jacquelyn Reed from all claims for injuries, damages, losses, death, costs, and expenses of all kinds, including legal fees, in any way arising from or related to therapeutic treatments received at any time from Balanced By Touch and Jacquelyn Reed.
- I have reported all health conditions that I am aware of and will inform my practitioner of any changes.

I understand the cancellation policy and know I will be charged $35.00 for appointments cancelled/rescheduled without 24 hours notice.

Signature _____ Date _____