Name: _____ Date: _____

Address: _____

City, State, Zip: _____

Telephone – Home: _____ Work/Cell: _____

Email: _____ Birth date: _____

Partner status: _____# of children: ____ Occupation: _____

Is there a possibility that you are pregnant? Yes ▢ No ▢ Are you nursing? Yes ▢ No ▢

What are you current health goals? What would you like to change or improve for your health/wellness?

_____

_____

General Health and Lifestyle

1. Do you exercise regularly? Yes ▢ No ▢ Times per week: _____

Length of time: _____ Type of exercise: _____

2. Do you experience any allergic reactions to any substances (food, environmental, etc)?

Yes ▢ No ▢ If yes, please describe: _____

3. Do you currently smoke? Yes ▢ No ▢ How many cigarettes per day? _____

How long have you smoked? _____

Have you ever smoked? Yes ▢ No ▢ If so, when did you quit? _____

4. Do you drink any caffeinated drinks? Coffee, black tea, etc. Yes ▢ No ▢

If yes, how much do you drink in a day? _____ What times of day? _____

5. Rate your level of stress (10 being overwhelming and 1 being mild stress)

With work/school life: _____ With primary intimate relationships: _____

6. Do you have any specific spiritual practice? Please describe:

Do you have children? Children: _____ Pregnancies: _____

Is there a possibility of your being pregnant now?

How were your pregnancies? (Of great importance is whether their pregnancies were stable or unstable.)

Have you ever had any major injuries or operations? (Entire life) _____

What happened? How was your recovery?

Major illness which required hospitalization?

Have you had a medical exam in the past year?
How was the testing?

Are you currently on medication? If Yes, please list medication?

Are you under the care of any other health care practitioner, traditional or orthodox?

Medical History

Please check any conditions that may apply to you. Also, please note next to each condition if either your parents or maternal or paternal grandparents had or have a history with any condition.

General:
____ Allergies
____ Cancer
____ Dizziness
____ Epilepsy
____ Fainting
____ Fatigue
____ Headaches
____ Mental disorder
____ Nervousness
____ Numbness

Muscles & Joints
____ Arthritis
____ Backache/Upper
____ Backache/Lower
____ Broken bones
____ TMJ/jaw pops
____ Mobility limitations
____ Spinal curvature
____ Sprained tendons/muscles
____ Stiff neck
____ Swollen joints

Gastrointestinal
____ Belching
____ Constipation
____ Abdominal pain
____ Colitis

Urinary
____ Excessive urination
____ Water retention

Women:
____ Menopausal
____ Hot flashes
____ Mood swings
____ Irregular cycle
____ Breast lumps
____ Infertility
____ Vaginal discharge
____ Lower back pain
____ Mood swings
____ Venereal disease

Cardiovascular:
____ Heart attack
____ Heart disease
____ High blood pressure
____ Low blood pressure
____ Pain in Heart Area
____ Poor circulation
____ Swelling of Ankles/Joints
____ Previous Heart Stroke/Murmur

Ears, Eyes, Nose, Throat
____ Asthma
____ Ear aches
____ Eye pains, Dry/Wet
____ Failing vision
____ Glaucoma
____ Sinus infection
____ Sore throat
____ Sinus congestion

Skin:
____ Boils
____ Acne
____ Dryness (lacking oil)
____ Dehydrated (lacking water)
____ Itching
____ Varicose veins
____ Inflamed/sensitive

Respiratory:
____ Asthma
____ Chest pain
____ Difficulty breathing
____ Dry cough
____ Spitting blood
____ Congestion

NOTE: For those of you who practice Ayurveda, you could add this part of the consultation.

Ayurvedic Profile: Please circle the descriptions that best describe you at this time in your life.

Digestion/Appetite	**VATA**	**PITTA**	**KAPHA**
Describe your hunger level	variable	strong	low
Reaction to missing meals	anxious/ lightheaded	irritable	not significant
Typical quantity of meals	medium/varies	large	small
Frequency of meals	irregular	regular	regular
Eating speed	quick	medium	slow
Digestion after eating	gas, bloating	heartburn,	heavy, sluggish
Elimination			
Frequency of bowel Movements (BM)	less than 1x a day	2 or more times a day	1 time a day
BM Tendency towards	constipation	loose, unformed	thick, sluggish
Level of comfort	straining, painful	burning	slow
Respiratory system:			
I am experiencing	dry nasal/lung passages/cough	burning/inflamed lungs/nasal/coughs	phlegm, congestion, wet cough
Skin:			
Recently, my skin has been:	Dry, dry patches In different areas	inflamed, heat heat rashes, redness	very oily

Any skin irritations, rashes, acnes, boils, eczema, etc.? Please describe:

_____

_____

Weight			
I currently feel:	underweight, have difficulty gaining	losing and gaining, weight easily	overweight, difficulty losing it

Temperature

I feel:	cold a lot	hot and irritated	cold and dull

Sleep

I have been having:	difficulty sleeping, Often awaken and Cannot fall back	difficulty falling once asleep, sleep soundly.	no problem sleeping, sleeping a bit Excessively.

Emotion wellbeing

I feel:	exhausted, restless, Anxious/nervous	tense and tired but determined	lethargic, low energy, don't want new projects
	Indecisive, chaotic, Difficulty focusing Or concentrating	judgmental, overly ambitious, negative	uninspired, very resistant to change

Stress

I have been feeling	Tearful, anxious	angry, aggressive, Confrontational	like I want to hide away

Menstruation/Menopause

Regularity	irregular/variable	regular	regular
Quantity of flow	light, variable	heavy	moderate, heavy
Emotions	overwhelmed, anxious	angry, irritable	sluggish, inertia

Informed Consent

I understand that this consultation is designed to gather information so that the practitioner is able to design and create aromatic products based upon my individual needs and for the express purpose of supporting health and well-being through lifestyle changes, health habits, and healthy mental well-being.

I understand that my aromatherapy practitioner (name) does not diagnose, prevent or treat any illness, disease, or any other physical or mental condition. I understand that I am consulting this practitioner for educational purposes only, of my own free will.

I understand that this treatment is not a substitute for medical treatments and it is recommended that I see a qualified professional for any physical or mental condition that I may have. I understand that any evaluation cannot determine a specific disease condition I may have, and that it does not replace the diagnostic services offered by licensed physicians.

I understand that _____ (Name) and/or their representatives will not suggest that I cease medical care I am undertaking. I understand that the decisions I make regarding my health care are my sole responsibility and I will not hold _____(name) or his/her representatives responsible for the consequences of my decisions.

I understand that _____ (Name) neither claims, nor implies, that any instruction, advice, counsel, suggestions, recommendations, services, or products he/she or his/her representatives provide, whether in person or by mail or by telephone, will cure, treat, prevent, or mitigate any disease condition; but are provided solely for the purpose of supporting the natural function of the body systems, and to improve general health and well-being.

I have read the above information and I hereby give my permission for _____ to design an aromatic program for me based upon my unique needs and goals.

**I have received a copy of this agreement. _____ (initial here)

Client name:_____

Client signature:_____

Date:_____