Consultation Form Aromatherapy

Personal Details

Name:

Address:

Postcode:

Occupation:

Emergency contact:

Tel:

Client No.:

Telephone (including code)

Day:

Evening:

Mobile:

Email:

Doctor:

Practice Address:

Postcode:

GP Practice:

General State of Health

Do you exercise regularly? no yes

Are you taking any medication? no yes

Are you on any special diet? no yes

Height:

Weight:

Date of birth:

How would you describe your stress levels? high medium low

How would you describe your energy levels? high medium low

Do you smoke? no yes, _____ cigarettes per day

Do you drink alcohol? no yes, _____ units per week

How would you describe your sleep patterns?

What do you do for relaxation?

Have you ever had an aromatherapy treatment? no yes

Reason for treatment?

Female clients:

Could you be pregnant? no yes, _____ weeks

Are you breast feeding? no yes

Date of last period?

Have you had an IUD fitted in the last 12 weeks? no yes

Conditions and/or Symptoms

Do you suffer from asthma conditions? no yes

Do you suffer from unstable blood pressure? no yes

Do you suffer from any heart disorders? no yes

Do you have a history of thrombosis/embolism? no yes

Do you have epilepsy? no yes

Do you have a dysfunction of the nervous system? no yes

Do you suffer from any infectious diseases? no yes

Do you suffer from any skin disorders? no yes

Do you have any severe bruising? no yes

Do you have any recent scar tissue? no yes

Have you recently suffered from a haemorrhage? no yes

Do you have any varicose veins? no yes

Do you suffer from any swelling/oedema? no yes

Do you have any recent cuts or abrasions? no yes

Have you recently had any operations? no yes

Do you have any other medical condition? no yes

Have you recently had any inoculations? no yes

Have you ever had or do you have cancer? no yes

Do you have any recent fractures or sprains? no yes

Are you currently suffering from a fever? no yes

Do you have diabetes? no yes

Do you have osteoporosis? no yes

Do you suffer from arthritis? no yes

Do you suffer from any back problems? no yes

Do you suffer from any allergies? no yes

Do you suffer from anxiety or depression? no yes

Do you suffer from headaches/migraines? no yes

Have you recently consumed alcohol? no yes

Have you recently consumed a heavy meal? no yes

Please give details if answered yes to any of the previous questions

Section For Use By Therapist

GP referral required: no yes

Clearance form sent: no yes Date:

Clearance form received: no yes Date:

Client Declaration: I declare that the information that I have given is true and correct and that, as far as I am aware, I can undertake treatment with this establishment without any adverse effects. I have been fully informed about contra-indications and am willing, therefore, to proceed. I understand that aromatherapy massage therapy is not a substitute for medical advice and/or treatment.

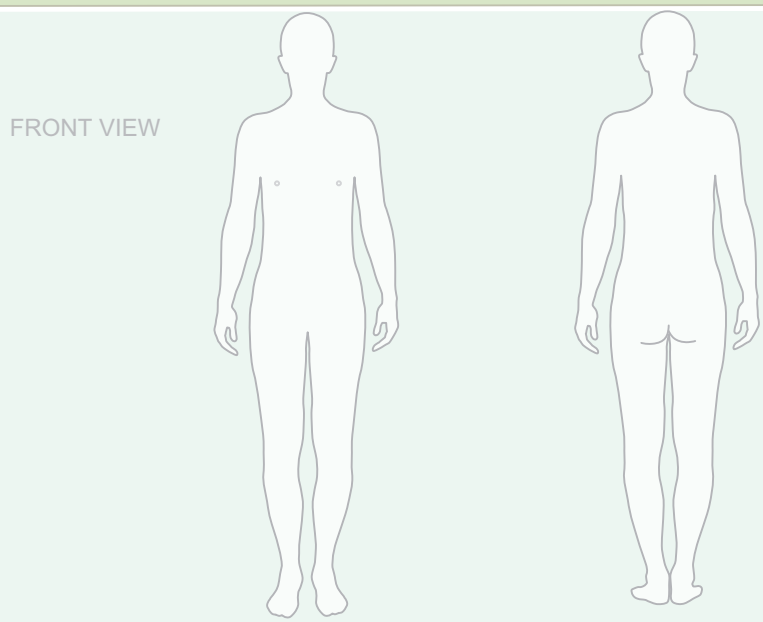
Client's signature: Date: Therapist's signature: Date:

Summary of Client's Main Presenting Problem/s

Main Condition			Second Condition			Third Condition		
Top	Middle	Base	Top	Middle	Base	Top	Middle	Base

Choice of Facial Oil:	Choice of Body Oil:
Essential oils _____ % Carrier oil _____ ml	Essential oils _____ % Carrier oil _____ ml
Reason for choice:	Reason for choice:

Treatment Plan



Date:	Reason for Treatment:	Treatment Aim:	Medium:
Comments:		Aftercare advice:	
	Therapist signature:	Date:	Client signature: Date:
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Comments:		Aftercare advice:	
	Therapist signature:	Date:	Client signature: Date:
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