

**Consultation for Aromatherapy Treatment**

**CLIENT INFORMATION**

CLIENT NAME.................................................................................................................................................................

TELEPHONE............................................................EMAIL……………………………………………………………………

**MEDICAL HISTORY**

CURRENT MEDICATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACCIDENTS, INJURIES, FALLS, OPERATIONS; (&APPROX DATES) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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XRAYS/TESTS IN LAST 3 YEARS: YES\_\_\_\_ NO\_\_\_\_ DETAILS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU RECEIVING ANY OTHER THERAPIES: YES\_\_\_ NO\_\_\_\_\_

ALLERGIES: YES\_\_\_ NO\_\_\_ TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL QUESTIONNAIRE:**

FEVER\_\_\_ FIRST TRIMESTER OF PREGNANCY\_\_\_\_ HISTORY OF THROMBOSIS\_\_\_ RECEIVING CANCER TREATMENT\_\_\_ DIARRHOEA/VOMITING\_\_\_ UNDER THE INFLUENCE OF ALCOHOL

HYPER/HYPOTENSION\_\_\_ HAEMOPHILIA\_\_\_OSTEOPOROSIS\_\_\_ EPILEPSY\_\_\_ DIABETES\_\_\_ RECENT OPERATIONS\_\_\_ ANY DYSFUNCTION OF THE NERVOUS SYSTEM\_\_\_ KIDNEY INFECTIONS\_\_\_ WHIPLASH/HEAD INJURY\_\_\_ HEART CONDITIONS\_\_\_ ARTHRITIS/RHEUMATISM\_\_\_

SKIN DISORDER/INFECTION\_\_\_HERPES SIMPLEX\_\_\_ CUTS/BRUISES/ABRASIONS\_\_\_ HEADACHES/MIGRAINE\_\_\_ SCAR TISSUE\_\_\_ SWELLING\_\_\_\_VARICOSE VEINS\_\_\_

NOTES ON ANY ADDITIONAL CONDITIONS/SYMPTOMS:

In line with GDPR regulation (May 2018), these details are **NOT** processed or stored electronically, but are used solely for providing you with the best treatment possible.

By ticking and signing this document, you are giving consent to have this information taken and stored, as well as re-visited prior to further treatments, to enable me to update your information if any answers to the questions have changed (for instance, a contra-indication).

I take these details to ensure the treatment is safe for you to receive, and that you are not contraindicated to the treatment in question.

You do, of course, have the right not to answer the following, but this could mean that your treatment will not go ahead, as we may not be able to obtain sufficient information to provide the treatment safely. You also have the right to view this information and/or have it removed completely from our records at any time.

I confirm I’m happy to have my information taken and stored, as well as re-visited prior to further treatments.

I have undertaken a medical consultation and completed a lifestyle questionnaire prior to the treatment, which is complete and accurate to the best of my knowledge.

I agree to notify the therapist of any change in my medical condition.

I have had the therapy explained to me.

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIFESTYLE

OCUPATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HRS PER WK\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU SEE DAYLIGHT AT WORK YES\_\_\_\_ NO\_\_\_\_ REGULAR BREAKS YES\_\_\_ NO\_\_\_

ABILITY TO RELAX: GOOD\_\_\_\_ POOR\_\_\_\_ AVERAGE\_\_\_\_

SLEEP PATTERNS: GOOD\_\_\_\_ POOR\_\_\_\_ RESTLESS\_\_\_\_ HRS PER NIGHT\_\_\_\_\_\_\_\_

DO YOU SMOKE: YES\_\_\_\_ NO\_\_\_\_ HOW MANY PER DAY\_\_\_\_\_\_

DO YOU DRINK ALCOHOL: YES\_\_\_\_ NO\_\_\_\_ UNITS PER WEEK\_\_\_\_\_

DO YOU DRINK TEA/COFFEE: YES\_\_\_\_ NO\_\_\_\_ CUPS PER DAY\_\_\_\_

HOW MUCH WATER DO YOU DRINK DAILY\_\_\_\_\_\_\_\_

EXERCISE: DAILY\_\_\_\_ WEEKLY\_\_\_\_ INFREQUENTLY\_\_\_\_ NEVER\_\_\_\_

TYPE OF EXERCISE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DO YOU FEEL PHYSICALLY (1-10).................... HOW DO YOU FEEL EMOTIONALLY?...........

STRESS LEVELS AT HOME (1-10)?.................... STRESS LEVELS AT WORK (1-10)?......................

WHAT SMELLS DO YOU USUALLY PREFER?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RANGE SHEET INFORMATION**

R1: OBJECTIVES

RELAXATION\_\_\_\_\_STIMULATING\_\_\_\_BALANCING\_\_\_\_ STRESS RELIEF\_\_\_\_

R2: APPLICATIONS  
COMPRESSES\_\_\_\_ OTHER MEDIA\_\_\_\_ INHALATION/VAPORISATION\_\_\_\_  
MASSAGE\_\_\_\_ IMMERSION\_\_\_\_

OTHER INFORMATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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BLENDING

TREATMENT NO ……….. DATE..............................

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| --- | --- | --- | --- |
| TREATMENT OBJECTIVES | TOP NOTES | MIDDLE NOTES | BASE NOTES |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

CHOICE OF OILS

FINAL BLEND:

TOP NOTE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DROPS:\_\_\_\_\_\_\_\_\_

MIDDLE NOTE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DROPS:\_\_\_\_\_\_\_\_\_

BASE NOTE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DROPS:\_\_\_\_\_\_\_\_\_

CARRIER OILS

BODY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_REASON\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FACE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_REASON\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONTRA-INDICATED OILS/SENSITIVITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TREATMENT PLAN

CONSIDER: AREAS OF THE BODY, APPLICATIONS, ADAPTION

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| AFTERCARE ADVICE:  GENERAL: \* \* \*  SPECIFIC: (ESSENTIAL OILS & APPLICATIONS FOR HOME USE)  \* \*  \* |

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| REFLECTIVE FEEDBACK  ......................................................................................................................................................................................................................................................................................................  ....................................................................................................................................................................................................................................................................................................................................................................................................................................................... |