Fragrant Aroma

Intake Form

Intake Date:

Client Name:	Age:
Occupation:	Gender:

REASON FOR VISIT	
1. Please describe your main wellness concern and symptoms. If you have more than one concern, please describe your top three.	**2. Month/Year of onset:**
3. Your idea of the cause(s):	
4. What makes it feel better? (examples: ice or heat, rest, reduce stress)	
5. What makes it feel worse? What connections, if any, do you notice between your symptoms and your lifestyle (sleep, stress, etc.)?	

HEALTH HISTORY		
6. Chronic Conditions:	[ ] High Blood Pressure	[ ] Low Blood Pressure
	[ ] Diabetes	[ ] Seizure Disorder
	[ ] Other Chronic Conditions:	
7. Do you have any allergies? If so, list below.		
8. Are you under the care of a physician? If so, list conditions you are being treated for below.		
9. Prescribed medications, over-the-counter drugs, vitamins, herbs, and supplements:		

10. Surgeries:	
Year	Type of Surgery

11. Do you have asthma or any lung conditions?	[ ] Yes	[ ] No
12. Are you experiencing any skin conditions?	[ ] Yes	[ ] No
13. Are you currently undergoing any treatment for cancer?	[ ] Yes	[ ] No
14. Do you have multiple chemical sensitivity?	[ ] Yes	[ ] No
15. Are you pregnant?	[ ] Yes	[ ] No
16. Are you trying to become pregnant?	[ ] Yes	[ ] No
17. Are you breastfeeding?	[ ] Yes	[ ] No

SOCIAL HISTORY			
18. Exercise	[ ] Sedentary (no exercise)		
	[ ] Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	[ ] Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	[ ] Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
19. Sleep	How many hours of sleep do you usually get per night?		
20. Caffeine	Do you drink caffeinated beverages?	[ ] Yes	[ ] No
	How much?		
21. Alcohol	Do you drink alcohol?	[ ] Yes	[ ] No
	How much?		
22. Tobacco	Do you smoke cigarettes or other forms of tobacco?	[ ] Yes	[ ] No
23. Others in the Home	Are there pets in the house? If so, type(s):	[ ] Yes	[ ] No
	Are there children in the house? If so, ages:	[ ] Yes	[ ] No
	Is there a pregnant person in the house?	[ ] Yes	[ ] No
	Are there elderly people in the house?	[ ] Yes	[ ] No

AROMATIC PREFERENCES
24. What particular aromas or scents do you especially enjoy? Do you associate them with anything specific?
25. What particular aromas or scents do you dislike or find disturbing? Please share a bit about your experiences.

OTHER INFORMATION
26. Have you had any experience with aromatherapy or essential oils before? If so, what are your favorite ways to use essential oils or aromatherapy products? (e.g. bath, lotion, diffuser, room/linen spray)
27. Do you have any questions or concerns about using essential oils?
28. Do you have any experience with alternative/complementary healing modalities (massage, acupuncture, etc.)?
29. Any other information (additional symptoms or concerns) you think we should know in order to work with you safely and effectively?