Aromatherapy Assessment and Intake

Name:----------

Address: ---------- Zip --------

Birthday--------- Occupation ---------

Married?----- Single?----- Divorced?----- Children?-----Ages-----

How is your general health? ----------

Last visit to MD? ---------- Why? ----------

Surgeries/Serious Illness? ---------- When? ----------

Please describe when and what procedure(s) ----------

Motor vehicle accident? ----- When? ----------

Nature of injuries: ----------

Falls or injuries? ----------

Do you experience headaches? ----- What time of day? -----

Sleep problems? ----- Do you wake up at night? -----

What time(s)? ----------

Stomach or digestion complaints? ----------

Reproductive/urinary complaints? ----------

General Stress Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
(no stress) (manageable) (unmanageable)

Comments:

Exercise regularly? ☐ yes ☐ no Frequency:

Do you smoke? ☐ yes ☐ no Frequency:

Consume caffeine? ☐ yes ☐ no Frequency:

(*Caffeine refers to coffee, tea, soft drinks, or any other caffeinated beverages.*)

Eating habits:

Check any that apply (*past or present*):

☐ Cancer	☐ Epilepsy	☐ Surgery	☐ Arthritis	☐ Heart disease
☐ Diabetes	☐ Contact lenses	☐ High blood pressure	☐ TMJ disorder	☐ Low blood pressure
☐ Dentures	☐ Allergies	☐ Hepatitis	☐ Paralysis	☐ Varicose veins
☐ Asthma	☐ Eczema	☐ Psoriasis	☐ Skin conditions	

Other conditions:

What medications are you taking presently and for what condition(s)? (*Medication refers to prescription drugs, herbal supplements, vitamins, etc.*)
Do you have any allergies? If so, please list them here.

Check any that you experience once or more per week:

☐ Headache	☐ Fatigue	☐ Insomnia	☐ Faintness/dizziness
☐ Constipation or Loose bowels	☐ Excessive urination	☐ Respiratory problems	☐ Cold hands/feet
☐ Stomach upsets - indigestion	☐ Nervousness	☐ Soreness in muscles	☐ Anxiety
☐ Pains in chest area or heart	☐ Poor appetite	☐ Trouble sleeping	☐ Tightness in body, where?
☐ Weakness in body, where?			

Other or comments from above:

For Women Only:

Are you trying to conceive? ----------

Are you pregnant? ----------

What kind of birth control do you use? ----------

Where are you in your menstrual cycle? ☐ Menstruating ☐ 1st week after ☐ 2nd week after ☐ 3rd week after ☐ 4th week after

Please list any PMS symptoms?----------

For Men Only:(Prostate/erectile dysfunction/premature ejaculation) Complaints:

High or low blood pressure? ----------

Any blood clots? ----------

Have you or anyone in your family ever had: Epilepsy----- Hepatitis----- HIV pos-----

TB---- Cancer----------, what type?---------- when?----------

Asthma? ----- Diabetes? ----- Heart problems----- what? ----------

Dermatitis (eczema, psoriasis, dandruff) ----------

Other immune condition----------

General dietary summary:

_____

For what purpose have you sought out Aromatherapy?
_____

_____

_____

What skin type are you?

Body:	☐	Normal	☐	Oily	☐	Dry	☐	Combination	☐	Sensitive	☐ Problem
Face:	☐	Normal	☐	Oily	☐	Dry	☐	Combination	☐	Sensitive	☐ Problem

Product Preference

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 ☐ Perfume/Cologne

Are there any scents you do not enjoy? (E.g.: floral, citrus, camphor, etc.)

Is there anything else I should be aware of that I have not already asked?

How did you hear about Tina M Johnson's services? ----------

Please answer the above as honestly and accurately as possible, as it enables me to better serve you and create a blend specifically for you. Please be aware, blends are created on the information collected within this form, please be honest as blends will change based on different information.

All information gathered in this intake form is private and confidential.

I understand aromatherapy 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. Also, aromatherapy is not meant to take the place of diagnosis or treatment by a qualified medical practitioner. By signing below I hereby state that to the best of my knowledge this intake form contains true, complete and correct information. The undersigned hereby releases and agrees to indemnify and hold harmless Tina M Johnson 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 Tina M Johnson.

Signature Date

Practitioner's Assessment

Comments or suggestions:

Noted essential oil safety contraindications/precautions:

Blend: