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| **PERSONAL DETAILS** |
| Name:  |  | Consultation Date: **/ /**  |
| Contact Number: |  |
| Address: |  | Gender: | Male Female |
|  | Date of Birth: |  **/ /**  |
|  | Occupation: |  |
|  |  |
| Email Address: |  |
| Marital Status: |  | Emergency Contact info:  |
| Children + Ages: |  |
| GP Name: |  | Name: |  |
| GP Address: |  | Telephone Number: |  |
|  |  | Relationship to Contact: |  |
| **THERAPY DETAILS** |
| Reason(s) for wanting Aromatherapy: |  |
| Expectations from the treatment: |  |
| Which kind of aromas do you like? |  |
| Which kind of aromas do you not like? |  |
| Have you previously had Aromatherapy or any other holistic treatment? | Yes No  |
| If Yes, What treatment & When did you have it? |  |
| Are you currently having any other forms of holistic (alternative / complimentary) treatments?  | Yes No  |
| If yes please provide details |  |

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| **MEDICAL & SURGICAL HISTORY** |
| Details of current medical conditions |  |
| Details of current medication |  |
| Details of any allergies that you have: |  |
| Details of hospitalisations/operations (conditions and dates)  |  |
| **Female Clients Only** |
| Date of Last Period: |  **/ /**  |
| Do you suffer from PMT/Menstrual Pains (please state how this affects you) |  |
| Are you pregnant (if so how many weeks)  |  |
| Are you trying to conceive  |  |
| Are you menopausal (if so how does it affect you) |  |
| Please indicate if you currently, or have ever, suffered from any of the conditions below (tick as many boxes as apply to you, please mark current conditions with an **X** and past conditions with a **P**): |
| **Circulation****---- Heart Conditions****---- Angina****---- Arteriosclerosis****---- High Blood Pressure****---- Low Blood Pressure****----Thrombosis****---- Varicose Veins** **----Fluid Retention****---- Cellulite****---- cold hands/feet** | **Skin Conditions****---- Dermatitis****---- Eczema****---- Psoriasis****---- Melanomas****---- Acne****---- Scars****---- Acne****---- Bites****----Burns****----Bruises****---- Athletes foot****---- Boils****---- Herpes****---- Rash****---- Warts/Verrucae** | **Digestive****---- Constipation****---- Diarrhoea****---- Bloating****---- Hernia****---- Stomach Problems****Joint & Muscular** **---- Back Problems****---- Broken Bones****---- Fractures****---- Dislocations****---- Pins/Plates****---- Sprain****---- pulled muscles****---- tight muscles****----joint problems****---- Arthritis****---- Osteoporosis****---- Trapped Nerve****---- Rheumatism** | **Mind/Mood****----Depression****---- Low Mood****---- Anxiety****----Insomnia****----stress****---- MH illnesses****Other****---- Cancer****---- Diabetes****----Epilepsy****---- Hepatitis (A B C)****---- HIV/AIDS****---- Multiple Sclerosis****---- Asthma****---- Parkinson’s****---- Motor Neurone****---- Bells Palsy****---- Kidney Infections****---- Hormonal Implants****---- Contagious disease****---- Alcohol Misuse****---- Drug Misuse** |
| **Any other diagnosed condition (please specify):** |

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| **LIFESTYLE** |
| Do you eat regular meals? |  |
| Do you have a well balanced diet? |  |
| Do you have regular bowel movements? |  |
| How many cups/glasses of water and non-caffeinated drinks do you drink per day? |  |
| How many cups/glasses of caffeinated (e.g. tea, coffee) drinks do you drink per day? |  |
|  |  |  |
|  |  |
|  |  |
| Do you drink alcohol? | Yes No | If Yes, approx. how many units per week & pattern of use?  |
| Do you smoke? | Yes No | If Yes, approx. how many cigarettes per day?  |
| Do you Exercise regularly? | Yes No | **If so, what type and so often:** |
| General Stress Level (1-10) [10=highest] |  |
| Your work hours per week (on average)? |  |
| What do you do to relax? |  |
| Hobbies / Interests: |  |
| What is your average hours sleep per night? |  |
| **CLIENT OBJECTIVES FOR INITIAL TREATMENT (to be completed by therapist)** |
| Please Circle: Uplift Relaxation Stress Relief  |
| **Key Aims of Treatment:** |
| 1. |
| 2. |
| 3. |
| **Oils chosen for Aromatherapy:** |
| **Carrier Oils** | **Amount (ml)** | **Essential Oils** | **Amount (no. of drops)** |
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| **Treatment Plan Including Home/Self Care: (Include Length of Plan)** |
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**Client Response**

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**Self Reflection**

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DECLARATION: “I confirm that the information given above is correct and that to my knowledge, I have not withheld any information that may be deemed relevant to my treatment. I will notify the therapist of any future changes in my health before receiving further treatments. I accept full responsibility for any problems arising from my omissions on this form, including relevant health conditions, medications and ongoing medical treatments.”

PLEASE NOTE: All information held about clients is held securely in strictest confidence.

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| Client Signature: | Date: / /  |

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| Therapist Signature: | Date: / /  |