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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.

|  |  |
| --- | --- |
| Client Signature: | Date: / / |

|  |  |
| --- | --- |
| Therapist Signature: | Date: / / |