CONSULTATION FORM

Name: _____ Date: _____

Address: _____

City, State, Zip: _____

Telephone—Home: _____ Work/Cell: _____

Email: _____ Birth date: _____

Partner status: _____# of children: ____ Occupation: _____

Is there a possibility that you are pregnant? Yes ▫ No ▫ Are you nursing? Yes ▫ No ▫

What are you current health goals? What would you like to change or improve for your health/ wellness? _____

_____

General Health and Lifestyle

1. Do you exercise regularly? Yes ▫ No ▫ Times per week: _____

Length of time: _____ Type of exercise: _____

2. Do you experience any allergic reactions to any substances (food, environmental, etc)?

Yes ▫ No ▫ If yes, please describe: _____

3. Do you currently smoke? Yes ▫ No ▫ How many cigarettes per day? _____

How long have you smoked? _____

Have you ever smoked? Yes ▫ No ▫ If so, when did you quit? _____

4. Do you drink any caffeinated drinks? Coffee, black tea, etc. Yes ▫ No ▫

If yes, how much do you drink in a day? _____ What times of day? _____

5. Rate your level of stress (10 being overwhelming and 1 being mild stress)

With work/school life: _____ With primary intimate relationships: _____

6. Do you have any specific spiritual practice? Please describe:

_____

_____

Medical History

Please check any conditions that may apply to you. Also, please note next to each condition if either your parents or maternal or paternal grandparents had or have a history with any condition.

General:
___ Allergies
___ Cancer
___ Dizziness
___ Epilepsy
___ Fainting
___ Fatigue
___ Headaches
___ Mental disorder
___ Nervousness
___ Numbness

Muscles & Joints
___ Arthritis
___ Backache/Upper
___ Backache/Lower
___ Broken bones
___ TMJ/jaw pops
___ Mobility limitations
___ Spinal curvature
___ Sprained tendons/muscles
___ Stiff neck
___ Swollen joints

Gastro-intestinal
___ Belching
___ Constipation
___ Abdominal pain
___ Colitis

Urinary
___ Excessive urination
___ Water retention

Women:
___ Menopausal
___ Hot flashes
___ Mood swings
___ Irregular cycle
___ Breast lumps
___ Infertility
___ Vaginal discharge
___ Lower back pain
___ Mood swings
___ Venereal disease

Cardiovascular:
___ Heart attack
___ Heart disease
___ High blood pressure
___ Low blood pressure
___ Pain in Heart Area
___ Poor circulation
___ Swelling of Ankles/Joints
___ Previous Heart Stroke/ Murmur

Ears, Eyes, Nose, Throat
___ Asthma
___ Ear aches
___ Eye pains, Dry/Wet
___ Failing vision
___ Glaucoma
___ Sinus infection
___ Sore throat
___ Sinus congestion

Skin:
___ Boils
___ Acne
___ Dryness (lacking oil)
___ Dehydrated (lacking water)
___ Itching
___ Varicose veins
___ Inflamed/sensitive

Respiratory:
___ Asthma
___ Chest pain
___ Difficulty breathing
___ Dry cough
___ Spitting blood
___ Congestion

Ayurvedic Profile: Please circle the descriptions that best describe you at this time in your life.

Digestion/Appetite	**VATA**	**PITTA**	**KAPHA**
Describe your hunger level	variable	strong	low
Reaction to missing meals	anxious/ lightheaded	irritable	not significant
Typical quantity of meals	medium/varies	large	small
Frequency of meals	irregular	regular	regular
Eating speed	quick	medium	slow

Digestion after eating	gas, bloating	heartburn,	heavy, sluggish

Elimination

Frequency of bowel Movements (BM)	less than 1x a day	2 or more times a day	1 time a day
BM Tendency towards	constipation	loose, unformed	thick, sluggish
Level of comfort	straining, painful	burning	slow

Respiratory System:

I am experiencing	dry nasal/lung passages/cough	burning/inflamed lungs/nasal/coughs	phlegm, congestion, wet cough

Skin:

Recently, my skin has been:	Dry, dry patches In different areas	inflamed, heat heat rashes, redness	very oily

Any skin irritations, rashes, acnes, boils, eczema, etc.? Please describe: _____

_____

_____

Weight

I currently feel:	underweight, have difficulty gaining	losing and gaining, weight easily	overweight, difficulty losing it

Temperature

I feel:	cold a lot	hot and irritated	cold and dull

Sleep

I have been having:	difficulty sleeping, Often awaken and Cannot fall back	difficulty falling once asleep, sleep soundly.	no problem sleeping, sleeping a bit Excessively.

Emotional Well-being

I feel:	exhausted, restless, Anxious/nervous	tense and tired but determined	lethargic, low energy, don't want new projects
	Indecisive, chaotic, Difficulty focusing Or concentrating	judgmental, overly ambitious, negative	uninspired, very resistant to change

Stress

I have been feeling	Tearful, anxious	angry, aggressive, Confrontational	like I want to hide away

Menstruation/Menopause

Regularity	irregular/variable	regular	regular
Quantity of flow	light, variable	heavy	moderate, heavy
Emotions	overwhelmed, anxious	angry, irritable	sluggish, inertia

Informed Consent

Aromatherapy is an incredible healing art and science that supports and enhances the individual's ability to heal and maintain health.

I understand that this consultation is designed to gather information so that my practitioner is able to design and create aromatic products based upon my unique needs and goals.

I understand that my aromatherapy practitioner (name) does not diagnose, prevent, or treat any illness, disease, or any other physical or mental condition.

I understand that this treatment is not a substitute for medical treatments and it is recommended that I see a qualified professional for any physical or mental condition that I may have.

This consultation does not take the place of a medical evaluation.

I have read the above information and I hereby give my permission for _____ to design an aromatic program for me based upon my unique needs and goals.

Client name:_____

Client signature:_____ Date:_____