Aromatherapy Intake Form

Name:	Date:	
Address:	State:	Zip:
Phone:	Email:	
DOB:	Age:	Occupation:

What is your primary concern?

Month/Year of onset of concern:
Your idea of the cause:

What makes it feel better?

What makes it feel worse?

Are you pregnant? **Are you trying to become pregnant?** **Are you breastfeeding?**

Chronic Conditions (please check)
___ High Blood Pressure
___ Low Blood Pressure
___ Epilepsy
___ Any seizure disorder other than epilepsy:
___ Allergies, please list:

Are you under the care of a physician? If so, please list the condition(s) you are being treated for:

Medications: Please list all medications, herbs and supplements you are taking:

Surgeries: Please list type and date of all surgeries:

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Social History

1. How much per day do you use of the following?

a) Coffee, tea, soft drinks

b) Alcohol

c) Cigarettes, cigars, tobacco

d) Other drugs

2. Please describe your current exercise regimen:

Hours per week: Activities: [ ] No Exercise

3. How many hours of sleep do you usually get per night during the week?

4. Please provide any other information that you think we should know in order to treat you safely and effectively:

Aroma Questions

Are there particular scents or aromas that disturb you?

Are there particular scents or aromas that you especially enjoy?

Do you have allergic reactions to any scents / Flowers / Trees? If so, which ones:

Dietary Questions

Are you allergic to any foods?

What is a typical dietary day for you (what do you eat for breakfast, lunch and dinner)? Please include drinks, snacks, and desserts.

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Other Concerns

Do you have other symptoms or concerns that have not been covered?

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Please read and sign:

I have stated all my known conditions and have answered all questions honestly. I take it upon myself to keep the practitioner updated on my health.

I understand that the consultant does not diagnose, prevent or treat illness, disease or any other physical or mental conditions.

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

I understand this treatment is not a substitute for medical care.

I have read the "Safety Information Page" and agree to follow of these guidelines.

I understand the following:

- I am not being advised to take any essential oil products internally
- I must keep all essential oil products out of the reach of children
- Essential oils could be poisonous if swallowed
- Essential oils must be stored in a cool, dark place
- Essential oils may irritate the skin if not stored or used properly
- Essential Oils must not be used with animals
- Essential Oils must not be used on the skin of babies or children under 1 years old
- Essential Oils must be used with extreme caution for children under 5 years old.

I hold my essential oil consultant, Jody Pesapane harmless for any injuries or negative effects I may experience as a result of using the products I receive from this consultation.

I hold Mindful Mixtures harmless for any injuries or negative effects I may experience as a result of using the products I receive from this consultation.

Client Signature Date