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 Karmassage? _____

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 Karmassage and Brandy Wiles-Credeur 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 Karmassage and Brandy Wiles-Credeur.

_____

Signature Date

Practitioner's Assessment

Comments or suggestions:

Noted essential oil safety contraindications/precautions:

Blend: