Consultation Record

PRIVATE & CONFIDENTIAL

naturra

1. PERSONAL INFORMATION

Name: _____ DOB _____ ☐Male ☐Female

Address:_____

_____Post code: _____

Mob: _____ Email_____

Marital Status: _____Dependants: _____

Emergency Contact Name_____ Tel No:_____

Height: _____ Weight: _____

What do you hope to gain from this Aromatherapy treatment?

_____

_____

_____

2. DOCTORS DETAILS

Doctors Name:

Address: _____

Tel No: _____

Date of last visit to the GP & reason: _____

Medication – Prescribed and over the Counter/Supplements: _____

_____

Operations/Accidents/Illnesses incl. dates: _____

_____

3. GP LETTER

Date sent: (if applicable) _____ Date of Reply: _____

Are you currently receiving treatment by a health care professional, either complementary or orthodox, including dentist or optician?

Details: _____

_____

Have you received this essential oil therapy before? _____

_____

How did you hear about me? _____

4. PERSONAL AND CLOSE FAMILY MEDICAL HISTORY (Blood Relatives Only):

Do any of your close relatives suffer from the following medical issues?

Vascular	☐**None**	☐Heart	☐Hypertension	☐Poor circulation	☐Thrombosis	☐Varicose Veins
Endocrine/Immune	☐**None**	☐Diabetes	☐Thyroid	☐ME	☐Lupus (SLE)	☐Headaches
Nervous Disorders	☐**None**	☐Epilepsy	☐Depression	☐Migraines	☐MS	☐Headaches
Digestion	☐**None**	☐Indigestion	☐Constipation	☐Ulcers	☐Colitis	☐Diarrhoea/IBS
Respiratory	☐**None**	☐Chest	☐Asthma	☐Bronchitis	☐Hay Fever	☐Sinusitis
Skin	☐**None**	☐Eczema	☐Allergies	☐Psoriasis	☐Athlete's Foot	☐Verrucae
Genito Urinary	☐**None**	☐Kidney	☐Bladder	☐Infertility	☐Other	
Other	☐**None**	☐Cancer	☐Arthritis	☐Rheumatism	☐Hepatitis	
Disabilities	☐**None**	☐Mental Health	☐Physical	☐Congenital	☐Other	
Special Senses	☐**None**	☐Eye defects	☐Contacts	☐Anosmia	☐Deafness	Other

Are you suffering from any infection diseases? ☐YES ☐ NO

Childhood illnesses _____

_____

Details on Medical History (to include details of X-rays and other medical tests/diagnosis):

Total Contraindications:	**Local Contraindications/Cautions**
Infectious/notifiable disease	Pregnancy
Current Migraine	Scar tissue/cuts/open wounds or sores/lacerations
Undiagnosed Oedema (consult GP)	Varicose Veins
Unexplained pain or inflammation (consult GP)	Allergies
	Epilepsy
	Asthma
	Medications
	Hepatitis
	Parchment Skin

Skin Type: _____

5. FEMALE HEALTH

Describe any issues with women's health and/or Menstrual Cycle:

_____

_____

Date of first day of last menstrual cycle:_____

Pregnancy: If you are pregnant how many weeks?_____

NOTES ON CONTRAINDICATION/CAUTIONS/SKIN ISSUES WHERE APPLICABLE

6. LIFESTYLE

Rate(✓) how satisfied you are with your health in the following areas:
0 =Very Unhappy - 10= Very Satisfied.

Emotional	⓪①②③④⑥⑦⑧⑨⑩
Physical	⓪①②③④⑥⑦⑧⑨⑩
Diet	⓪①②③④⑥⑦⑧⑨⑩
How would you rate stress levels?	⓪①②③④⑥⑦⑧⑨⑩
What causes the most stress in your life?	
What techniques do you use to manage stress?	
How would you describe yourself? ☐Optimistic ☐Pessimistic ☐Confident ☐Nervous Have you suffered any bereavements, if so when? _____ Do you have any phobias?_____	

How many times a week do you take physical exercise	⓪①②③④⑥⑦⑧⑨⑩
What are the greatest blockages to you exercising?	

How much fluids to you drink per day? _____

Do you smoke? ☐ YES/ ☐NO Number per day:_____

Do you drink? ☐YES ☐NO Number of units per week: _____

Describe your sleeping pattern _____

7. CLIENT DECLARATION

I confirm that all the information given during this consultation is accurate to my knowledge and I consent to receiving an aromatherapy treatment

I consent to _____*who is in my charge receiving aromatherapy treatment**
*(*Delete as appropriate)*

Client Name/Guardian (Print) _____

Signature: _____Date: _____

Therapist's signature: _____Date: _____

THERAPIST _____ **DATE**_____