Hazel Mae's Healing Hands

Aromatherapy Client Intake Form

Aromatherapy is a form of alternative medicine that uses essential oils (EOs), and other aromatic compounds from plants for the purpose of affecting a person's mood or health.

Name: _____ Birthdate: _____

Address: _____ Telephone: _____

City: _____

State: _____ Referred by: _____

Zip: _____

Please take a moment to carefully read the following questions and explain as needed.

What are your current health goals?

What would you like to change or improve for your health and wellness?

Do you have sensitive skin?

If so, please list any issues you experience.

Do you have any allergies or sensitivities to oils, lotions, scents, foods, medicine, plants, etc.?

Do you frequently suffer from stress?

Stress with primary intimate relationships:

Do you smoke? If so, how much in a day?

Do you have hypertension (high blood pressure)?

Are you under the care of a physician or chiropractor?

If so, for what reason?

Are you currently taking any medication?

Emotional and Psychological Well Being

Rank yourself from 1-10 (1=do not struggle with 10= daily struggle)

1. Anger (expressed, verbal or physical)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
2. Anger (unexpressed or internal)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
3. Anxiety	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
4. Apathy	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
5. Depression	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
6. Suicidal emotions or tendencies	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
7. Insomnia	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
8. Lethargy (can't get started)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
9. Digestive trouble	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
10. Fear	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
11. Grief	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
12. Lowered Self-Esteem	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
13. Loss/Death	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
14. Mental stress	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
15. Calming	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
16. Physical pain	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
17. Oversensitivity/Irritability	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
18. Spiritual protection	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
19. Stress (overall)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

Please answer yes or no.

a.	Would you say that you have a hard time dealing with sadness or possessiveness?	O Yes O No
b.	Would you say that you have been trying too hard or perhaps pretending that you're ok when your really not?	O Yes O No
c.	Do you feel that you may struggle with worrying too much or obsessing (about anything?)	O Yes O No
d.	Do you struggle with anger, resentment, bitterness or frustration on a consistent basis?	O Yes O No
e.	Would you have a tendency to say that you live in fear, or struggle with fear?	O Yes O No
f.	Do you feel that on a day to day basis you have a tendency to struggle with any or all of the emotions mentioned above?	O Yes O No

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
____ 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

GastroIntestinal:
____ 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

Cardiovascular:
____ Heart attack
____ Heart disease
____ High blood pressure
____ Low blood pressure
____ Pain in Heart Area
____ Poor circulation
____ Swelling of ankles/joints
____ Previous Heart
Stroke/murmor

Ears, Eyes, Nose, Throat:
____ Asthma
____ Ear aches
____ Eye pains, Dry/Wet
____ Failing vision
____ Glaucoma
____ Sinus infections
____ 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

Informed Consent

Aromatherapy is an incredible healing art and science that supports and enhances the individuals' 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, Shannon Kittrick-Sylvain does not diagnose, prevent or treat any illness, disease, or any other physical or mental condition.

I understand that this 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 Shannon Kittrick-Sylvain to design an aromatic program for me based upon my unique needs and goals.

I understand that essential oils and aromatherapy is a complementary holistic therapy and not intended to treat, diagnose, and/or cure any medical issues. I affirm that I have answered all questions accurately and honestly. And realize the importance of notifying the practitioner of any changes that may affect my health profile and understand that there shall be no liability on the practitioner's part should I forget to do so. I know that I need to seek medical attention by a proper qualified health professional when appropriate. I understand that all my information is strictly confidential and maintained at all times. Upon request, I may give my permission to the practitioner to use my information in a case study and may request a copy of the case study if so desired. I appreciate the practitioner's dedication to using the highest quality, therapeutic grade essential oils.

Client Signature_____ Date_____

Practitioner Signature_____ Date_____