Aromatherapy Intake Form

Patient Information

Patient Name: _____ DOB: _____ Sex: _____

Home Phone: _____ Cell: _____

Address: _____

Medical History

Current Chronic Conditions: _____

Current Acute Conditions: _____

Most Problematic Symptoms: _____

Treatments: _____ Effective? _____

Current Medications: _____

Recent Surgeries: _____

Allergies: _____

Are you pregnant? ❑ Yes ❑ No Trying? ❑ Yes ❑ No Breastfeeding? ❑ Yes ❑ No

Do you have epilepsy? _____ High/low blood pressure? _____ Hours sleep per night: _____

Exercise Activities: _____ Hours per week: _____

Aromatherapy

Reason for Visit: _____

Most Pleasing Scents/Oils: _____

Least Pleasing Scents/Oils: _____

Allergies/Irritations to any Scents/Oils: _____

Other Information: _____

Concerns: _____

I understand that Essential Oils are for external use only, and must be kept in a cool, dark place. I will stop using Essential Oils if they cause skin irritation or other unpleasant reactions. I understand that Essential Oils are **not** for use on infants under the age of one year, and should be used with caution on children under the age of five years.

I hold my aromatherapist harmless for any and all injuries, reactions, or illnesses resulting from these aromatherapy sessions or provided products.

_____ _____

Patient Date