Natural Healing Centers

Aromatherapy Intake Form

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ City, State: _____ Zip: _____

Phone: _____ Email: _____ Male / Female

Date of Birth: _____ Age: _____ Occupation: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Phone #: _____

Reason for Visit: _____

What is your primary concern? _____

Month/ Year of onset? _____

Your idea of the cause: _____

What makes it better? _____

What makes it feel worse? _____

Are you expecting? Yes No Are you trying? Yes No Are you breastfeeding? Yes No

CHRONIC CONDITIONS (Please check all that apply)

__ Allergies, please list:

_____

__ Any Seizure Disorders other than epilepsy, if so, please list:

_____

__ Epilepsy

__ Low Blood Pressure

__ High Blood Pressure

Are you under the care of a physician? Yes or No If so, please list the condition(s)

you are being treated for:

_____

_____

_____

List of Medications:

_____

_____

_____

_____

Surgeries:

_____

_____

SOCIAL HISTORY

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

Coffee, tea, soft drinks: _____ Alcohol: _____

Cigarettes, cigars, tobacco: _____ Other drugs: _____

2. Please describe your current exercise regimen:

__ Do not exercise

Hours per week: _____

Activities: _____

_____

3. How many hours of sleep do you usually get per night? _____

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

effectively: _____

_____

_____

AROMA QUESTIONS:

Are there particular aromas that disturb you? If so, please list:

_____

_____

Are there particular aromas that you enjoy? If so, please list:

_____

_____

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

_____

_____

Do you have any plant allergies? If so, please list:

_____

_____

OTHER CONCERNS:

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

_____

_____

_____

_____

Forms Completed By: _____ Date: _____