

*Client Intake Form for Aromatherapy Consultation*

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Today’s Visit:

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How long have you been experiencing your problem or issue?

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Is there anything that makes it better or worse? (If so, please describe)

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Have you received any medical care for this problem? If so, please list the name of the provider and the approximate date of your visit with her/him.

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Are you allergic to any plants, foods, or medications? If so, please list.

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Are you currently pregnant or breastfeeding? If pregnant, how far along are you and who is your doctor or nurse-midwife?

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Do you have any diagnosed medical conditions? If so, please list the condition and the name of the provider who treats you for it.

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Do you take or use any prescription medications, over-the-counter medications, vitamins, herbal supplements, or recreational drugs? If so, please list name and reason for use. (Responses are confidential and will not be shared outside of this practice.)

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What is your height & weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is your age? \_\_\_\_\_\_\_\_\_\_\_\_

What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco products? \_\_\_\_\_\_\_\_\_\_ Do you consume alcohol? \_\_\_\_\_\_\_\_\_\_

Do you have any small children, pets, or someone who is medically frail in your household? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you previously used essential oils? If so, please list name of oil (i.e., lavender, peppermint, etc.), method of use (diffuser, topical use, etc.) and any physical reactions.

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Are there any particular aromas that you either really enjoy or strongly dislike?

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Do you participate in any other holistic wellness care or protocols? If so, please list (such as yoga, chiropractic care, Reiki, acupuncture, massage, etc.).

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Please list anything else you feel might be helpful for me to know (such as previous emotional trauma or physical injuries, dietary restrictions, important personal beliefs, religious observations, etc.).

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I understand that in order for my aromatherapist to form a safe and effective personalized aromatherapy plan for me, it is important to provide complete answers to the questions on this form. I understand that any information I provide to my aromatherapist will be held in confidence and will not be shared without my written permission. I verify that I have provided accurate information and I agree to update my aromatherapist as soon as possible if any of the information changes. I understand that aromatherapy is not medical care, no product that I receive from Dancing Bee Naturals is to be considered medication that can prevent, treat, or cure any disease, and that I should seek professional medical care for any health-related issues.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_