Love You Best

Aromatherapy Assessment and Intake

Name: _____

Address: _____ Zip _____

Birthday_____ Occupation _____

Married? _____ Single? _____ Divorced? _____ Children? _____ Ages_____

How is your general health?

_____

Last visit to MD? _____ Why? _____

Surgeries/Serious Illness? _____ When? _____

Please describe when and what procedure(s)

_____

_____

Motor vehicle accident? _____ When? _____

Nature of injuries:

_____

Falls or injuries?

_____

Do you experience headaches? _____ What time of day? _____

Sleep problems? _____ Do you wake up at night? _____

What time(s)? _____

Stomach or digestion complaints?

_____

Reproductive/urinary complaints?

_____

General Stress Level: 1 2 3 4 5 6 7 8 9 10

(No stress 1-3) (Manageable 4-6) (Unmanageable 7-10)

Contributing stress factors:

Exercise regularly? Yes No Frequency:

Do you smoke? Yes No Frequency:

Consume caffeine? Yes No Frequency:

(*Caffeine refers to coffee, tea, soft drinks, or any other caffeinated beverages.*)

Eating habits: Check any that apply (*past or present*):

Allergies

Arthritis

Asthma

Cancer

Contact lenses

Dentures

Diabetes

Eczema

Epilepsy

Heart disease

Hepatitis

High blood pressure

Low blood pressure

Paralysis

Psoriasis

Skin conditions

Surgery

TMJ disorder

Varicose veins

Other conditions:

What medications are you taking presently and for what condition(s)? (*Medication refers to prescription drugs, herbal supplements, vitamins, etc.*)

Do you have any allergies? If so, please list them here.

Allergies:

Check any that you experience once or more per week:

Anxiety

Cold hands/feet

Constipation or Loose bowels

Excessive urination Respiratory problems

Faintness/dizziness

Fatigue Insomnia

Headache

Nervousness Soreness in muscles

Pains in chest area or heart

Poor appetite

Stomach upset or indigestion

Tightness in body, where?

Trouble sleeping

Weakness in body, where?

Other or comments from above:

For Women Only:

Are you trying to conceive? _____

Are you pregnant? _____

What kind of birth control do you use? _____

Where are you in your menstrual cycle? Menstruating 1st week after 2nd week after 3rd week after 4th week after

Please list any PMS symptoms?

_____

_____

For Men Only:

(Prostate/erectile dysfunction/premature ejaculation) Complaints:

_____

High or low blood pressure? _____

Any blood clots? _____

Have you or anyone in your family ever had: Epilepsy_____ Hepatitis_____ HIV pos_____

TB____ Cancer_____, what type? _____, when?_____

Asthma? _____ Diabetes? _____ Heart problems_____ what? _____

Dermatitis (eczema, psoriasis, dandruff) _____

Other immune condition_____

General dietary summary:

_____

_____

_____

For what purpose have you sought out Aromatherapy?

_____

_____

_____

What skin type are you?

Body: Normal, Oily, Dry, Combination Sensitive Problem

Face: Normal, Oily, Dry, Combination Sensitive Problem

Product Preference: Please write any product you are uninterested in receiving or if there are any scents you do not enjoy. (E.g.: floral, citrus, camphor, etc.)

Is there anything else I should be aware of that I have not already asked?

How did you hear about **Love You Best?** _____

Answering the above as honestly and accurately as possible, enables **Love You Best** to better serve you and create the blend best for you.

Please be aware, blends are created based on the information collected within this form, (being honest is the best way to benefit you) blends will change based on different information.

All information gathered in this intake form is private and confidential.

Understanding aromatherapy is not to be thought of as a cure for ailments, rather that aromatherapy is an alternative treatment used to help alleviate symptoms of ailments. Aromatherapy is not meant to take the place of diagnosis or treatment by a qualified medical practitioner. By signing below I hereby state that to the best of my knowledge this intake form contains true, complete and correct information.

The undersigned hereby releases and agrees to the above stated facts in regards to liability towards **Love You Best** from claims of injuries, damages, and expenses of all kinds, including legal fees, in any way arising from or related to therapeutic treatments received at **Love You Best**

_____

Signature Date

For Office Use Only:

Assessment:

Comments or suggestions:

Noted essential oil safety contraindications/precautions:

Blend: