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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ****Client confidential Intake Form**** | | | | | | Date of Intake: | | | | | | | | |
| Full Name: | | | | | | | | |
|  | | | |  | | | | |
| Client Number or Nickname: | | | | | | | Age: |  | | | | | | |
| **Occupation**: | | | | | **Gender**: F | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| reason for visit | | | | | | | | | | | | | | |
| 1. Please describe your main wellness concern and symptoms.  If you have more than one concern, please describe your top three. | | | | 2. Month/Year of onset: | | | | | | | | | | |
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| 3. Your idea of the cause(s): | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| 4. What makes it feel better? (examples: ice or heat, rest, reduce stress) | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| 5. What makes it feel worse? What connections, if any, do you notice between your symptoms and your lifestyle (sleep, stress, etc.)? | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | |
| health history | | | | | | | | | | | | | | |
| 6. Chronic Conditions: | | | [ ] High Blood Pressure | | [ ] Low Blood Pressure | | | | | | | | | |
| [ ] Diabetes | | [ ] Seizure Disorder | | | | | | | | | |
| [ ] Other Chronic Conditions: | | | | | | | | | | | |
| **7. Do you have any allergies? If so, list below.** | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | |
| **8. Are you under the care of a physician? If so, list conditions you are being treated for below.** | | | | | | | | | | | | | | |
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| 9. Prescribed medications, over-the-counter drugs, vitamins, herbs, and supplements: | | | | | | | | | | | | | | |
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| 10. Surgeries: | | | | | | | | | | | | | | |
| Year | Type of Surgery | | | | | | | | | | | | | |
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| 11. Do you have asthma or any lung conditions? | | | | | | | | | | [ ] | | Yes | [ ] | No |
| 12. Are you experiencing any skin conditions? | | | | | | | | | | [ ] | | Yes | [ ] | No |
| 13. Are you currently undergoing any treatment for cancer? | | | | | | | | | | [ ] | | Yes | [ ] | No |
| 14. Do you have multiple chemical sensitivity? | | | | | | | | | | [ ] | | Yes | [ ] | No |
| 15. Are you pregnant? | | | | | | | | | | [ ] | | Yes | [ ] | No |
| 16. Are you trying to become pregnant? | | | | | | | | | | [ ] | | Yes | [ ] | No |
| 17. Are you breastfeeding? | | | | | | | | | | [ ] | | Yes | [ ] | No |
|  | | | | | | | | | | | | | | |
| SOCIAL HISTORY | | | | | | | | | | | | | | |
| 18. Exercise | | [ ] Sedentary (no exercise) | | | | | | | | | | | | |
| [ ] Mild exercise (i.e., climb stairs, walk 3 blocks, golf) X | | | | | | | | | | | | |
| [ ] Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | | | | | | | | | |
| [ ] Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | | | | | | | | | |
| 19. Sleep | | How many hours of sleep do you usually get per night? 8 | | | | | | | | | | | | |
| 20. Caffeine | | Do you drink caffeinated beverages? | | | | | | | [ ] | | Yes | | [ ] | No |
|  | | How much? Daily | | | | | | | | | | | | |
| 21. Alcohol | | Do you drink alcohol? | | | | | | | [ ] | | Yes | | [ ] | No |
| How much? | | | | | | | | | | | | |
| 22. Tobacco | | Do you smoke cigarettes or other forms of tobacco? | | | | | | | [ ] | | Yes | | [ ] | No |
| 23. Others in the Home | | Are there pets in the house? If so, type(s): 2 dogs | | | | | | | [ ] | | Yes | | [ ] | No |
| Are there children in the house? If so, ages: | | | | | | | [ ] | | Yes | | [ ] | No |
| Is there a pregnant person in the house? | | | | | | | [ ] | | Yes | | [ ] | No |
| Are there elderly people in the house? | | | | | | | [ ] | | Yes | | [ ] | No |
|  | | | | | | | | | | | | | | |

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| AROMATIC PREFERENCES |
| **24. What particular aromas or scents do you especially enjoy? Do you associate them with anything specific?** |
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| **25. What particular aromas or scents do you dislike or find disturbing? Please share a bit about your experiences.** |
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|  |
| OTHER INFORMATION |
| **26. Have you had any experience with aromatherapy or essential oils before? If so, what are your favorite ways to use essential oils or aromatherapy products? (e.g. bath, lotion, diffuser, room/linen spray)** |
|  |
| **27. Do you have any questions or concerns about using essential oils?** |
|  |
| 28. Do you have any experience with alternative/complementary healing modalities (massage, acupuncture, etc.)? |
|  |
| 29. Any other information (additional symptoms or concerns) you think we should know in order to work with you safely and effectively? |
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