

Aromatherapy/Energy Healing Consultation Form

Please Put your Personal Information on this page and sign the bottom

Your Practitioner _____

Your Name _____ Address _____

Telephone _____ Age _____ Email _____

Living Situation _____ Occupation _____

Spiritual Practice _____ Physician _____

Other health providers _____

Presenting Concern/Issue _____

(This box is for the practitioner to complete)

Mutual Goals: _____

Medical History:

Heart _____ Liver/gall bladder _____ Kidneys _____

Thyroid _____ Nervous system _____ Headaches _____

Stomach _____ Pancreas _____ Colon _____

Lungs _____ Back and joints _____ Reproductive system _____

Surgeries _____

Accidents _____

Current Medications _____

Systems Assessment:

Appetite _____ Digestion _____ Respiratory _____

Lymphatic _____ circulation _____

Skin: Normal _____ Dry/sensitive _____ Oily _____ combination _____

Other skin conditions _____

Muscular-skeletal injuries _____ Stiffness _____ Pain _____

Arthritis _____ Menstrual cycle: regular _____ Dysmenorrhea/PMS _____

Menopausal difficulties _____

Male: Prostate _____ Impotence _____ Other _____

Stress Level: (tell me about your stress level at home and at work) _____

Self Care Activities: (What do you do to deal with your stress level) _____

Client Signature _____ date _____