Aromatherapy Interview and Assessment Form

Name____**Date**________________________
Address____
Phone______________________________________Birthday/Age__________________________
Email_______________________________________Occupation__________________________
Married_______Single_______Divorced_______Children_______Ages____________________
Living Situation______________________ Spiritual Practice_____________________________
Primary Healthcare Provider (Physician)____
Other Health Providers____

Presenting concern____
____

Allergies or Sensitivities____
Surgeries: What Procedures?____
When?____
Serious illnesses____
Motor Vehicle Accidents____
Falls/Injuries____
Sleep Quality: How Much_____________________ Sleep aide____________________________
Do You Wake at night?______________ Insomnia______________________________
Exercise: Regularly □Yes □No Frequency_______ What Kind?__________________________
Daily Water Consumption____
Caffeine Consumption______ (coffee, tea, chocolate, soft drinks) □ Y □ N Frequency________
Do you Smoke? □ Yes □ No

Eating Habits:____
____
Food Allergies? □ Yes □ No What kinds? ____

Medications? □ Yes □ No List: ____
____
Supplements? □ Yes □ No List: ____
____
Homeopathics? □ Yes □ No List:____
Herbals? □ Yes □ No List: ____
Essential Oils? □ Yes □ No List: ____
Flower Essences? □ Yes □ No List:____

Skin Type:
Face: Normal___Dry___Oily___Combination
Body: Normal___Dry___Oily___Combination

Check All That Apply Past or Present:
Heart disease____ Gall Bladder_____ Hepatitis____ Kidney____ Thyroid____ Nerves ____
Stomach_____ Pancreas_____ Colon____ Lungs_____ Back and joints_____ Reproductive system_____ Hormonal system_____ Bones_____ Muscles_____

Have You Ever Had:
Cancer? Where? ____

Do You Presently Have:
Skin Issues: Eczema/Dermatitis____ Acne____ Scars____ Dandruff____ Psoriasis____
Hair loss____ Herpes Simplex____ Athlete's Foot_____ Warts_____
Other_______________________________________

Digestion Issues: Heartburn____ Indigestion____ Bloating Gas_____ Diarrhea____
Constipation____ Nausea____ Vomiting____ Mouth Sores____ Colitis_____ Irritable Bowel_____

Circulation Problems: Heart Palpitations____ Tightness in Chest____ Low Blood Pressure____
High Blood Pressure____ Fluid Retention____ Varicose Veins____ Shortness of Breath____ Blood Clots____ Lymph Edema____ Poor Circulation_____

Nervous System Issues: Depression_____ Headaches: Sinus_____ Tension_____ Migraine____
Neuralgia_____ Shingles_____ Neuropathy_____ Stroke_____ Parkinson's _____
Multiple Sclerosis_____ Seizure Disorder_____ Dementia or impaired memory_____

Respiratory Issues: Sore Throat____ Cold____ Flu____ Sinus Issues____ Bronchitis____
Pneumonia_____ Shortness of Breath____ Asthma____ Swollen Glands_____

Muscle Problems: Cramps____ Sprains____ Arthritis____ Rheumatism____ Back or Joint issues____ Jaw Pain_____ Inflammation_____ Spasms_____

Urinary Issues: Frequency____ Bladder Infections____ Stones____ Kidney Infection_____

Endocrine Issues: Thyroid Dysfunction_____ Adrenal Dysfunction_____ Diabetes_____
For Women:
Menstrual Cycles Regular____ Irregular Periods____ Menstrual Pain_____ PMS_____
Vaginal Thrush_____ Infertility_____ Herpes_____ Endometriosis_____
Pregnant____ Trimester____ First_____ Second____ Third____ Menopausal_____
Hot flashes____ Bloating____ Night Sweats_____ Irritability_____
Other____

For men:
Infertility____ Prostate Issues__________________________________ Complaints____

Pain scale [1-10 with 1 being none and 10 being worst): _____
Stiffness____Inflammation_____

Have You Been Diagnosed With:
Bacterial Infection_____ Viral Infection______ Fungal Infection_____

Any Other Long-Term Health Issue? ____

Emotional Issues:
Anxiety____ Depression____ Worry____ Fear____ Anger____ Apathy____ Empty____
Grieving a Loss____ Who?__________________ Despair_____ Disappointment_____
Sorrow_____ Anger_____ Frustration_____ Impatience_____ Apprehension_____
Powerlessness____ Terror_____ Panic Attacks_____ Resentment_____ Remorse_____
Regret_____ Lethargy_____ Listlessness_____ Boredom_____ Moodiness_____ Mood Swings_____ Inadequacy_____ Unworthiness____ Lacking Confidence_____
Suicidal____ Do You Have a Plan?____
Mental Fatigue____ Irritable_____

Mental Issues:
Difficulty in Concentrating____ Constant Irritability____ Lack of Interest in Life____
Feeling Unable to Cope____ Dreading the Future____ Fear of Being Alone____

Stress:
How Would You Rate Your Stress Level? □ Low □ Medium □ High
Lack of Appetite____ Unnatural Craving____ Constant Tiredness____ Frequent Crying or Wish to Cry____ Nail Biting____ Nervous Twitches____ Inability to Sit Still____

Work____
Home____
____

Self Care Activities:
____
____

Fragrance Preference: ____

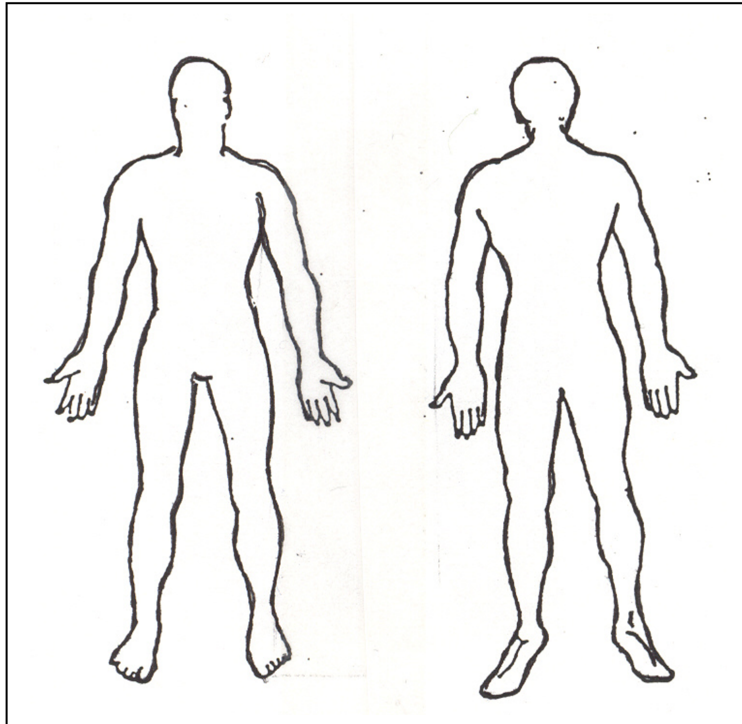
Client Signature: ____ Date _____________

Short Term Goal:____
____

Long Term Goals:____
____
____

Energy Assessment – Male

Client's Name___________________________



Energy Centers Before Session

7
6
5
4
3
2
1

Energy Centers After Session

7
6
5
4
3
2
1

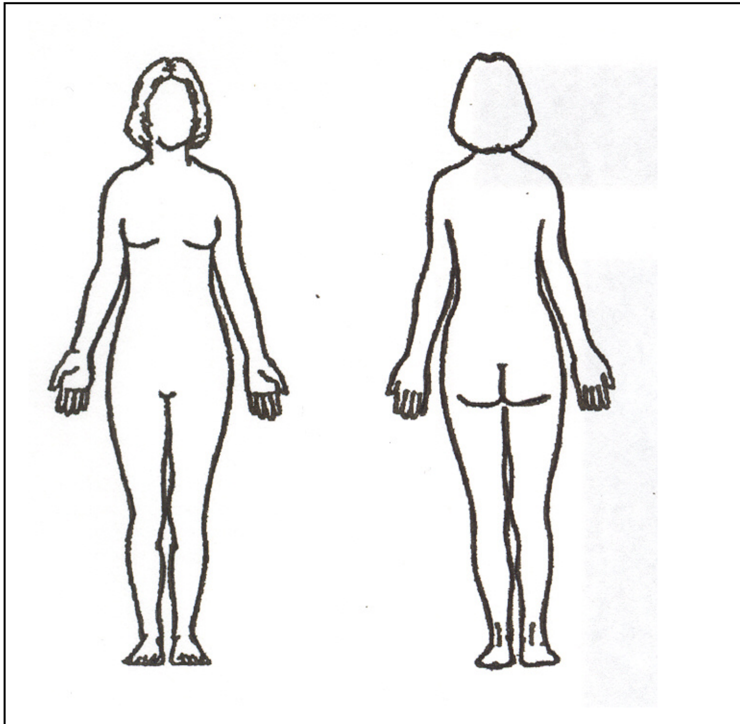
Interventions—What interventions were done for the client. (Include rationale).
Intentions offered: □ Verbal □ Silent
Healing Techniques Used and Why:____
____
____
____.
Essential Oils Chosen and Why:____
____
____.
Blends Created: ____
____
Method of Application:____

Relate your experience during the session: What did you notice, sense, feel, intuit with the client or yourself.____
____
____

What was the client's experience (in their own words) ______________________________________
____
____

Recommendations/Referrals:____
Next Appointment:____

Energy Assessment – Female **Client's Name**____________________________



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Next Appointment:____