



Client Consultation Form – Aromatherapy

College name:

Student Name:

College Number:

Student Number:

Client Name:

Date:

Address:

Sex: Male Female

Tel. No: Day..... Eve.....

GP Address:

PERSONAL DETAILS

Age group: Under 20 20–30 30–40 40–50 60+

Usual visit to Therapist:

Lifestyle: Active Sedentary

Last visit to the doctor:.....

No. Of children (if applicable):

Date of last period (if applicable).....

CONTRAINDICATIONS: (tick where appropriate)

- Any form of infection, disease or fever Under the influence of recreational drugs or alcohol Diarrhoea
- Vomiting Pregnancy(first trimester) Any form of general medication Pregnancy (use only mandarin)
- Cardio vascular conditions Haemophilia Any condition already being treated by a GP or another complementary practitioner Medical oedema Osteoporosis Arthritis Nervous/Psychotic condition Epilepsy Recent operations Diabetes Asthma Any dysfunction of the nervous system Bells Palsy Trapped/Pinched nerve Inflamed nerve Skin cancer Cancer Postural deformities Spastic conditions Kidney infections Whiplash Slipped disc Undiagnosed pain
- When taking prescribed medication Acute rheumatism Skin diseases Undiagnosed lumps and bumps Localised swelling Inflammation Varicose veins Pregnancy Cuts Bruises Abrasions Scar tissue Sunburn Hormonal implants Abdomen(first few days of menstruation) Haematoma Hernia Recent fractures Cervical Spondylitis Gastric ulcers After a heavy meal Conditions affecting the neck

WRITTEN PERMISSION REQUIRED BY:

GP/Specialist Client disclaimer

Either of which should be attached to the consultation form

PERSONAL INFORMATION

Muscular/Skeletal problems: Back Aches/Pain Stiff joints Headaches

Digestive problems: Constipation Bloating Liver/Gall bladder Stomach

Circulation: Heart Blood pressure Fluid retention Tired legs Varicose veins Cellulite
Kidney problems Cold hands and feet

Gynaecological: Irregular periods P.M.T Menopause H.R.T Pill Coil Other

Nervous system: Migraine Tension Stress Depression...

Immune system: Prone to infections Sore throats Colds Chest Sinuses

Regular antibiotic/medication taken? Yes No If yes, which ones

Herbal remedies taken? Yes No If yes, which ones

Ability to relax: Good Moderate Poor

Sleep patterns: Good poor Average No. of hours.....

Do you see natural daylight in your workplace? Yes No

Do you work at a computer? Yes No If yes how many hours.....

Do you eat regular meals? Yes No

Do you eat in a hurry? Yes No

Do you take any food/vitamin supplements? Yes No If yes, which ones

How much of each of these items does your diet contain?

Fresh fruit:..... Fresh vegetables:..... Protein:(source?)..... Dairy produce:.....
Sweet things:..... Added salt:.....Added sugar:.....

How many daily drinks of tea:..... Coffee:..... Fruit juice:..... Water:.....
Soft drinks... Others:.....

Do you suffer from food allergies? Yes No **Binging?** Yes No **Overeating?** Yes No

Do you smoke? No Yes How many per day?.....

Do you drink? No Yes How many units per day?

Do you exercise? None Occasional Irregular Regular Types.....

What is your skin type? Dry Oily Combination Sensitive Dehydrated

Do you suffer/have you suffered from: Dermatitis Acne Eczema Psoriasis Allergies
Hay fever Asthma Skin cancer

Stress level: 1-10 (10 being the highest)

Reason for treatment:

Rationale for the choice of carrier oil

Rationale for the choice of each essential oil

Indication of alternative oils that could have been used

Exact amount of carrier oil and essential oil blended:-

Base Oilmls

Essential Oil (in drops)

Essential Oil (in drops)

Essential Oil (in drops)

Details of how the therapist conducted the treatment

Details of how the client felt during and after the treatment

A client profile must be included in the case study

Student/Therapist Signature

Client Signature

Aromatherapy – *Follow up Sheet*

Any changes to the original consultation

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Rationale for the choice of carrier oil

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Rationale for the choice of each essential oil

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Indication of alternative oils that could have been used

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Exact amount of carrier oil and essential oil blended:

Carrier oil.....mls

Essential oil (in drops).....

Essential oil (in drops).....

Essential oil (in drops).....

Details of how the therapist conducted the treatment

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Details of home care advice given

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Overall conclusion of the case study including reflective practice.....

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Date of treatment