CLIENT CONSULTATION RECORD **Private & Confidential**
THERAPIST NAME:

Name	**Date**
Feedback from previous treatment: this treatment: home treatments:	
General state of health (1-10: 10=tops)	Exercise:
Allergies and intolerances	
Current medication (inc. self-prescribed, vitamins etc)	Diet
Sleep pattern	
Back/Spine	Tobacco/alcohol/other
Muscular	
Skin & skin type	Hobbies/relaxation
Headaches (frequency and pattern)	
Immune system (eg colds, sores)	
Respiratory	Emotional/stress
Digestive/excretory	
Reproductive (last period/pregnancy)	
Circulatory/cardiac	
Any of listed conditions:	Other therapies
Other	

NOTES:
Any changes since your last appointment (eg address, telephone number, job, partner, medication, new accidents/illnesses, contraindications, visits to dentist/optician, long haul flights, inoculations etc).

CLIENT DECLARATION
Signed consent on file
Resign if circumstances change signficantly

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Notes		
Treatment given and notes on treatment		
Essential Oils & Latin names	Main chemical components	Drops
Notes on oils		
Carrier Oils		Drops
Percentage dilution		=
After care advice given:		
Home care treatment provided or to follow up:		
Date of next appt		