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

Name		
Address	Post Code	
Tel Home		Tel Work
Mobile		Email
Emergency contact		Tel:
Date of birth		Marital Status
Dependants		
Height		Weight (or dress/shirt size)
Occupation		

Doctor's Name	
Address	Post Code
Tel No	

Date of last visit to GP and reason

Medication – Prescribed and over the counter (OTC) supplements

Operations/Accidents/Illnesses including dates

CLIENT DECLARATION
I confirm that all the information given during this consultation is accurate to my knowledge and I consent to receiving aromatherapy treatment from THERAPIST

Signature (Guardian if applicable) **Date**

I consent to the above named client ho is in my charge receiving aromatherapy treatment

THERAPIST signature Date

Personal and close family medical history (blood relatives only)					
Body System	*Check if GP diagnosed & include date:*				
Vascular	Heart	Hypertension Hypotension	History of haemorrage	Thrombosis	Varicose Veins
Endocrine/Immune	Diabetes	Thyroid	ME	Lupus (SLE)	HIV/Aids
Nervous disorders	Epilepsy	Depression	Migraines (current)	MS	Headaches
Digestion	Indigestion	Constipation	Ulcers	Colitis	Diarrhoea/IBS
	Hepatitis	Under influence of alcohol	Eaten large meal	Feeling nauseous or sick	
Respiratory	Chest pains	Asthma	Bronchitis	Hay Fever	Sinusitis
Skin & Skin Type	Eczema	Allergies	Psoriasis	Athlete's foot	Verrucae
	Scar tissue	Open wound	Bruising	Fungal nail infections	Sunburn
Muscular & Skeletal	Fractures	Arthritis	Rheumatism	Osteoporosis	
Genito/Urinary	Kidney	Bladder	Infertility	Other	
Other	Cancer	Odema	Hepatitis	Pregnancy – how many weeks	
	Unexplained pain or inflammation	Fever	Recent inoculation	Other	
Disabilities	Mental Health	Physical	Congenital	Other	
Special Senses	Eye defects	Contact lenses	Anosmia	Deafness	Other

Notes

Details on Medical History (to include details of X-rays and other medical tests/diagnosis)
Are you suffering from any infectious disease: Describe Childhood illnesses:
Women's Health & Menstrual Cycle Date of first day of last menstrual cycle if known Menopausal symptoms
Are you currently receiving treatment by a health care professional, either orthodox or complementary, including dentist and/or optician? If YES please describe Have you received this treatment before?
Notes where applicable

LIFESTYLE	
How do you consider your general state of health?	
What do you hope to gain from this treatment?	
Diet – including fluids per day	
Tobacco/alcohol/recreational drugs	
Describe your sleeping pattern	
Do you consider your lifestyle stressful and if so why?	
How do you cope with stress	
Do you take regular exercise and what type?	
Relationships, responsibilities, spirit and how do you cope?	
What do you do for relaxation and how often?	

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

Client Name		
Date		
Treatment given and notes on treatment Type of patch test used if applicable		
Essential Oils & Latin Names	Main chemical components	Drops
Notes on oils		
Carrier Oils		Drops
Percentage dilution		=
After care advice given:		
Home care treatment provided		
Date of next appointment:		