Aromatherapy Client Intake Form

Sarah C. Bellman, LMT, BS

Name_____ **Birthday**_____

Address_____ **Telephone**_____

City_____ **State**_____ **Zip**_____

Email_____

Occupation_____ **For how long?** _____

Referred By? _____

Partner status (Please Circle One): Married, Single, Divorced, Widowed

Number of Children and Ages_____

Please take a moment to carefully read the following questions and explain as needed.

What are your current health goals?

What would you like to change or improve for your health and wellness?

Do you have sensitive skin?

If so, please list any issues you experience.

Do you have any allergies or sensitivities to oils, lotions, scents, foods, medicine, plants, etc?

Do you frequently suffer from stress?

Please rate your level of stress with 10 = overwhelming and 1 = mild

Stress with work or school:

Stress with primary intimate relationships:

Do you smoke? If so, how much in a day?

Do you have hypertension (high blood pressure)?

Are you under the care of a physician or chiropractor?

If so, for what reason?

Are you currently taking any medication?

If so, for what reason?

Case Study for: **Date:**

Are you currently pregnant or breastfeeding?

How often do you exercise or engage in physical activity?

How much water do you drink in a day?

Do you have any specific spiritual practice?

Are you interested in learning more about essential oils and their benefits via email, social media?

What are your goals and/or desired outcomes for incorporating aromatherapy into your plan of care?

Medical History

Please check any conditions that may apply to you. Also, please note next to each condition if either your parents or maternal or paternal grandparents had or have a history with any condition.

General:	**Urinary:**	**Ears, Eyes, Nose, Throat:**
_____ Allergies	_____ Excessive urination	_____ Asthma
_____ Cancer	_____ Water retention	_____ Ear aches
_____ Dizziness		_____ Eye pains, Dry/Wet
_____ Epilepsy		_____ Failing vision
_____Fainting		_____ Glaucoma
_____ Headaches	**Women:**	_____ Sinus infections
_____ Mental disorder	_____ Menopausal	_____ Sore throat
_____ Nervousness	_____ Hot flashes	_____ Sinus congestion
_____ Numbness	_____ Mood swings	
	_____ Irregular cycle	
Muscles & Joints:	_____ Breast lumps	**Skin:**
_____ Arthritis	_____ Infertility	_____ Boils
_____ Backache/Upper	_____ Vaginal discharge	_____ Acne
_____ Backache/Lower	_____ Lower back pain	_____ Dryness (lacking oil)
_____ Broken bones		_____ Dehydrated (lacking water)
_____ TMJ/jaw pops		_____ Itching
_____ Mobility limitations		_____ Varicose veins
_____ Spinal curvature	**Cardiovascular:**	_____ Inflamed/sensitive
_____ Sprained tendons/muscles	_____ Heart attack	
_____ Stiff neck	_____ Heart disease	
_____ Swollen joints	_____ High blood pressure	**Respiratory:**
	_____ Low blood pressure	_____ Asthma
GastroIntestinal:	_____ Pain in Heart Area	_____ Chest pain
_____ Belching	_____ Poor circulation	_____ Difficulty breathing
_____ Constipation	_____ Swelling of ankles/joints	_____ Dry cough
_____ Abdominal pain	_____ Previous Heart	_____ Spitting blood
_____ Colitis	Stroke/murmor	_____ Congestion

Case Study for: **Date:**

Ayurvedic Profile

Please circle the descriptions that best describe you at this time in your life.

Digestion/Appetite	**VATA**	**PITTA**	**KAPHA**
Describe your hunger level	variable	strong	low
Reaction to missing meals	Anxious/lightheaded	irritable	Not significant
Typical quantity of meals	Medium/varies	large	small
Frequency of meals	irregular	regular	regular
Eating Speed	quick	medium	slow
Digestion after eating	Gas/bloating	heartburn	Heavy, sluggish
Elimination			
Frequency of bowel movements	less than 1x a day	2 or more times a day	1 time a day
BM Tendency towards	constipation	Loose, unformed	Thick, sluggish
Respiratory System			
I am experiencing	Dry nasal/lung	Burning/inflamed	Phlegm/congestion
	Passages/cough	Lungs/nasal/coughs	Wet cough
Skin			
Recently my skin has been	Dry, dry patches	Inflamed/heat	Very oily
	In different areas	Heat rashes/redness	
Weight			
I currently feel	Underweight, have difficulty gaining	Lose and gain weight easily	Overweight, difficulty losing it
Temperature			
I feel	Cold a lot	Hot and irritated	Cold and dull
Sleep			
I have been having	Difficulty sleeping, often awaken and cannot fall back asleep	Difficulty falling once asleep, sleep soundly	No problem sleeping, sleeping a bit excessivley
Emotion Wellbeing			
I feel	Exhausted, restless, anxious, nervous	Tense, tired but determined	Lethargic, low energy, don't want new projects
	Indecisive, chaotic, difficulty focusing or concentrating	Judgemental, overly ambitious, negative	Uninspired, very resistant to change

Sarah C Bellman, LMT, BS
www.sarahbellman.massagetherapy.com

Case Study for: **Date:**

Stress			
I have been feeling	Tearful, anxious	Angry, aggressive, confrontational	Like I want to hide away
Menstruation/Menopause			
Regularity	Irregular/variable	regular	regular
Quantity of flow	Light/variable	heavy	Moderate/heavy
Emotions	Overwhelmed/anxious	Angry/irritable	Sluggish/inertia

Informed Consent

Aromatherapy is an incredible healing art and science that supports and enhances the individuals' ability to heal and maintain health.

I understand that this consultation is designed to gather information so that my practitioner is able to design and create aromatic products based upon my unique needs and goals.

I understand that my aromatherapy practitioner, Sarah Bellman, LMT does not diagnose, prevent or treat any illness, disease, or any other physical or mental condition.

I understand that this is not a substitute for medical treatments and it is recommended that I see a qualified professional for any physical or mental condition that I may have.

This consultation does not take the place of a medical evaluation.

I have read the above information and I hereby give my permission for Sarah Bellman to design an aromatic program for me based upon my unique needs and goals.

I understand that essential oils and aromatherapy is a complementary holistic therapy and not intended to treat, diagnose, and/or cure any medical issues. I affirm that I have answered all questions accurately and honestly. And realize the importance of notifying the practitioner of any changes that may affect my health profile and understand that there shall be no liability on the practitioner's part should I forget to do so. I know that I need to seek medical attention by a proper qualified health professional when appropriate. I understand that all my information is strictly confidential and maintained at all times. Upon request I may give my permission to the practitioner to use my information in a case study and may request a copy of the case study if so desired. I appreciate the practitioner's dedication to using the highest quality, therapeutic grade essential oils.

Client Signature_____ **Date**_____

Practitioner Signature_____ **Date**_____

Aim or Outcome

Sarah C Bellman, LMT, BS
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Case Study for: **Date:**

Care Plan

Botantical name of essential oil (common name). If available include the country of origin, name of supplier, batch number

Full Details of blend (dilution, rationale for selection of each essential oil, carrier oil)

Treatment: Massage / Home

Chosen Essential Oil	***Indication***	***Amount***

Client Response

Subsequent Treatments (follow up)

Results

Discussion (my perspective)

References