Aromatherapy Consultation
Confidential Intake Form

Name ____ Date _____________

Address ____ State ______ Zip _______

Phone (_____) ________________ E-mail _____________________________________

Date of Birth __________________ Age ______ Occupation _______________________

Reason for Visit

What is your primary concern? ____

Month/Year of onset of concern ____

Your idea of the cause ____

What makes it feel better? ____

What makes it feel worse? ____

Your Health and Lifestyle History

1. Within the last year, have you been under a physician's care? ☐ Yes ☐ No
2. Within the last year, have you been under a dermatologist's care? ☐ Yes ☐ No
3. Within the last nine months, have you undergone any surgery? ☐ Yes ☐ No

   If yes, please specify ____

4. Have you had any of these health problems in the past or present?

   ☐ cancer ☐ diabetes ☐ epilepsy ☐ heart problem ☐ hormone imbalance ☐ spinal injury
   ☐ hysterectomy ☐ thyroid condition ☐ varicose veins ☐ systemic disease

5. Do you smoke? ☐ Yes ☐ No
6. Do you exercise regularly? ☐ Yes ☐ No
7. Do you follow a restricted diet? ☐ Yes ☐ No
8. Do you have regular sleep patterns? ☐ Yes ☐ No
9. Do you wear contact lenses? ☐ Yes ☐ No
10. Do you have metal implants or a pacemaker? ☐ Yes ☐ No

11. Rate your level of stress on a scale of 1-4 (1=low, 4= high) _______

12. Are you currently using Biore or snore strips? ☐ Yes ☐ no

13. Are you currently using any medication to treat any conditions of the skin? ☐ Yes ☐ no

    If yes, what are you using and how often? ____

14. Do you suffer from sinus problems? ☐ Yes ☐ no

Your Medical History

Are you pregnant? ______________ Are you trying to become pregnant? ______________________________

Are you breastfeeding? _______

If under the care of a physician, please list the condition(s) you are being treated for:
____
____

Any **ACUTE** Health Issues? ❒ Yes ❒ No
Comments:____
____
____

Any **CHRONIC** Health Issues? ❒ Yes ❒ No
Comments:____
____
____

Any **EMOTIONAL** Stresses? ❒ Yes ❒ No
Comments:____
____
____

Any **PHYSICAL** Stresses? ❒ Yes ❒ No
Comments:____
____
____

Any **ALLERGIES**? ❒ Yes ❒ No

❒ **FOOD Allergies**
Comments:____

____

❒ **POLLEN Allergies**
Comments: ____

____

❒ **ANIMAL Allergies**
Comments: ____

____

❒ **MEDICATION Allergies**
Comments: ____

____

❒ Exposure to **PETROCHEMICALS**?
Comments: ____

____

❒ Any **SKIN** sensitivities?
Comments: ____

____

❒ **Other Allergies**?
Comments: ____

____

ASTHMA? ❐ Yes ❐ No
Comments:

LUNGS/RESPIRATORY Issues? ❐ Yes ❐ No
Comments:

DIGESTIVE/INTESTINAL Issues? ❐ Yes ❐ No
Comments:

ENDOCRINE/REPRODUCTIVE Issues? ❐ Yes ❐ No
Comments:

HEART/CIRCULATION problems? ❐ Yes ❐ No
Comments:

BLOOD PRESSURE: HIGH? ❐ Yes LOW? ❐ Yes
Comments:

EPILEPSY? ❐ Yes ❐ No
Comments:

Any seizure disorder other than epilepsy? ❐ Yes ❐ No
Comments:

URINARY SYSTEM Issues? ❒ Yes ❒ No
Comments:____
____
____

History of DISEASES? ❒ Yes ❒ No
Comments:____
____
____

Notable INJURIES? ❒ Yes ❒ No
Comments:____
____
____

Notable SURGERIES? ❒ Yes ❒ No
Comments:____
____
____

MEDICATIONS, HERBS, VITAMINS & SUPPLEMENTS
Please list any and all medications, herbs and daily supplements, including vitamins & diuretics, that you are taking:

____
____

Your Skin

1. With what temperature water do you cleanse? ☐ cool ☐ warm ☐ hot

2. Do you have any special skin problems pertaining to your face or body? ☐ Yes ☐ No
   If yes, please specify ____

3. What skin care products are you currently using including your daily regimen?
   ☐ soap ☐ cleanser ☐ toner ☐moisturizer ☐ masque ☐ exfoliator
   ☐ eye products ☐ others _______

4. Do you have regular collagen, Restylane and or Botox injections? ☐ Yes ☐ No

5. Have you ever used products that caused a bad reaction? ☐ Yes ☐ No
   If yes, what did you use? ___________________
   What happened? ____
   ____

6. Do you currently have a sunburn, windburn, and/or irritated face? ☐ Yes ☐ No

7. Do you have rosacea? ☐ Yes ☐ No

8. Do you have any active forms of dermatitis, eczema or psoriasis on the area(s) that is (are) to be treated? ☐ Yes ☐ No If yes, where?
   ____

9. Do you have a tendency to scar or form keloid scars? ☐ Yes ☐ No

Moisture Hydration

1. How much plain water do you consume daily? ___________________________________
2. Do you drink caffeinated beverages (coffee, tea, soft drinks)? ☐ Yes ☐ No
   How many daily? ______________
3. How many alcoholic beverages do you consume weekly? __________________________
4. Do you ever experience these conditions with your skin?
   ☐ flakiness ☐ tightness ☐ obvious dryness
5. What SPF sunscreen do you use on your face? ________ Body? ________
6. Do you sunbathe or use tanning beds? ☐ Yes ☐ No

Capillary Activity

1. Do you burn easily in moderate sunlight? ☐ Yes ☐ No
2. Do you blush easily when nervous? ☐ Yes ☐ No
3. Do you have a tendency to redness? ☐ Yes ☐ No

Oil Secretion

1. Do you ever experience oily shine during the day? ☐ Yes ☐ No ☐ Occasionally
   If yes, approximately how many hours after cleansing your skin? 1 2 3 4 5 6 7 8
2. Do you ever experience skin breakouts? ☐ Yes ☐ No ☐ Occasionally

Aroma Preferences

Are there particular scents or aromas that disturb you?____

Are there particular scents or aromas that you especially enjoy? _____________________________________

Do you have allergic reactions to any scents? If so, which ones: _____________________________________

Please indicate your LIKES / DISLIKES for each fragrance category:

Floral	❒ Yes	❒ No
Citrus	❒ Yes	❒ No
Herbaceous	❒ Yes	❒ No
Woodsy	❒ Yes	❒ No
Earthy	❒ Yes	❒ No
Spicy	❒ Yes	❒ No
Exotic	❒ Yes	❒ No

Other Concerns

Do you have other symptoms or concerns that have not been covered?

____

____

CONSULTATION SESSION GOALS – CLIENT GOALS

Aromatherapy CONSULTATON – TWO PERSONAL BLENDS

PHYSICAL GOALS

- ❒ Aid HEALING of surgery incisions, injuries, wounds
- ❒ Reduce INFLAMMATION
- ❒ Ease PAIN
- ❒ Minimize SCAR formation
- ❒ Support ENDOCRINE balance/function
- ❒ SUPPORT KIDNEY health/function
- ❒ Fatigue
- ❒ Insomnia
- ❒ Thyroid
- ❒ Other

MENTAL / EMOTIONAL ISSUES

- ❒ Reduce ANXIETY / STRESS
- ❒ Ease DEPRESSION / GRIEF
- ❒ Aid FOCUS / MENTAL CLARITY
- ❒ FATIGUE
- ❒ PANIC ATTACKS

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Please Read Carefully and Sign:

I have stated all my known conditions and have answered all questions honestly. I take it upon myself to keep the consultant updated on my health. I understand that the consultant does not diagnose, prevent or treat illness, disease or any other physical or mental conditions. I understand that this treatment is not a substitute for medical treatments and/or diagnosis, and it is recommended that I see a qualified professional for any physical or mental condition that I may have.
I understand this treatment is not a substitute for medical care.

Initial Here: _______ I have read the "Safety Information Page" and agree to follow these guidelines. (this is available on the Inshanti website).

I understand the following – Please "check" each box to indicate your understanding:

- ❐ I am not being advised to take any essential oil products internally.
- ❐ I must keep all essential oil products out of the reach of children.
- ❐ Essential oils could be poisonous if swallowed.
- ❐ Essential oils must be stored in a cool, dark place.
- ❐ Essential oils may irritate the skin if not stored or used properly. Essential Oils must not be used on the skin undiluted. Essential Oils must be kept away from eyes and mucous membranes.
- ❐ Essential Oils must not be used with animals.
- ❐ Essential Oils must not be used on the skin of babies or children under a year old.
- ❐ Essential Oils must be used with extreme caution for children under 5 years old.

Initial Here: ________ I hold my essential oil consultant, Debra A. Stoltzfus and The Essence of Inshanti, harmless for any injuries or negative effects I may experience as a result of using the products I receive from this consultation.

I hereby acknowledge that I have answered these health and skin questions to the best of my ability, not withholding any information to the consultant that could in any way interfere with the results of the treatments I receive here.

____ __________________

Client Signature Date

____

Print Name (Client)