The Institute of
Traditional Herbal Medicine
and Aromatherapy

Practitioner's Name:
Consultation Date:

CLIENT CONSULTATION FORM

Client's Name:	Date of Birth:
Address:	Current Occupation:
	No. of Children:
	Doctor's Name:
Tel:	Tel:
Mobile:	Next of Kin:
Email:	Tel:

How are you hoping to benefit from aromatherapy treatment?

Do you have any current health problems?

Are you currently taking any medication, or undergoing any kind of treatment? (conventional or complementary)

Have you previously had any significant illnesses or operations?

Have you had any accidents or injuries that still affect you in any way?

Do you suffer with allergies of any kind?

Do you suffer with any type of skin disorder?

Have you been diagnosed with any of the following? ~

☐ Asthma	☐ High or low blood pressure
☐ Epilepsy	☐ Varicose veins, phlebitis or thrombosis

Would you say that you have good levels of energy? (Are you often tired?)

Do you have trouble getting to sleep, or waking during the night?

Do you take some form of regular exercise?

Do you suffer with backache, aching muscles or joint pain?

Are you especially sensitive to either warm or cold surroundings?

Do you often feel thirsty?

Do you sweat very easily?

Do you often get headaches?

Do you ever have a problem with your eyes, or vision?

Do you ever have difficulty breathing? Or feel congested with mucus?

Do you eat regular meals?

Do you ever feel bloated and uncomfortable after eating? (Are you prone to indigestion?)

Do you regularly consume the following? ~

☐ Sugary foods (such as cakes and biscuits)	☐ Deep-fried foods, cheese or butter
☐ Sugary drinks (such as fizzy drinks)	☐ Caffeinated tea and coffee

How many servings of fresh fruit and vegetables do you eat each day?

Do you have regular bowel movements? (Are you ever constipated?)

Do you ever have any problems with passing water? (urinating)

Are you a smoker?

Do you regularly use recreational drugs?

How many units of alcohol do you think you consume in a week, on average?
(1 unit = half pint of bitter or pub measure of spirit/ 1.5 units = small glass of wine or bottle of 5% lager/ 2 units = large glass of wine)

☐ 0 - 7	☐ 8 - 14	☐ 15-21	☐ 21 +

FEMALES: *Is there any possibility you may be pregnant?*

Do you menstruate regularly?

Do you suffer with PMT or menstrual pain?

How stressed are you, and how well do you cope with stress?

How would you describe your emotional well-being?

TONGUE SIGNS: Shape:	
Body Colour:	
Coating:	

PATTERNS OF DISHARMONY:	Relevant Symptoms:
1.	
2.	
3.	

ESSENTIAL OILS (common and botanical names)	QUANTITY (drops/ml)	Relevant Patterns/Symptoms:
1.		
2.		
3.		
4.		
5.		

CARRIER OIL/ QUANTITIES:

CLIENT CONSENT prior to treatment:

The information I have given is, to the best of my knowledge, accurate. The practitioner has explained the treatment, and I consent to receiving it, as well to the sharing of anonymous information for supervision purposes.

Client's signature: **Date:**

MASSAGE TREATMENT OUTLINE:
HOME ADMINISTRATION METHODS (where applicable):

CLIENT FEEDBACK following treatment:

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Practitioner's Name:
Consultation Date:

ONGOING TREATMENT SHEET

Client's Name:	Treatment No:

How have you been since your last visit?

ESSENTIAL OILS (common and botanical names)	QUANTITY (drops/ml)	Relevant Patterns/Symptoms:
1.		
2.		
3.		
4.		
5.		

CARRIER OIL/ QUANTITIES:

CLIENT CONSENT prior to treatment:

The information I have given is, to the best of my knowledge, accurate. The practitioner has explained the treatment, and I consent to receiving it, as well to the sharing of anonymous information for supervision purposes.

Client's signature: Date:

MASSAGE TREATMENT OUTLINE:

HOME ADMINISTRATION METHODS (where applicable):

CLIENT FEEDBACK following treatment: