Aromatherapy Client Intake Form

Practitioner	Date	Case Number

Client's Name

Client Contact Information

Address:	
Phone #:	
Email address:	
DOB:	Occupation

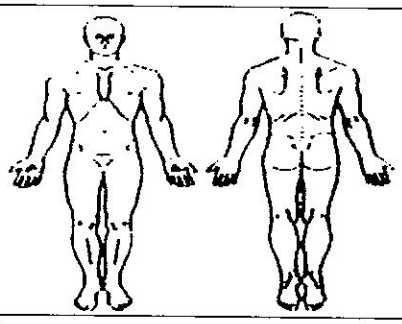
Principle Condition

How severe is the principle condition?
How long has the client had the principle condition?

Medical History

Headaches (type and frequency)					
Sleep					
Digestion					
Reproductive System		Pregnant		Breastfeeding	
Skin	Normal/Oily	Normal/Dry	Eczema	Other	

Circle areas of concern on the diagram to the right.



Stress Level	High	Medium	Low
Comments			

Other conditions to be aware of:

Medications:

-
-
-
-

Additional Comments

Essential Oils Used and Proportions

Carrier Oil(s) Used and Amounts

Dates Seen	Condition(s)	Comments