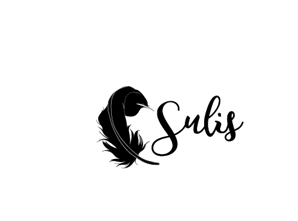
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**Client Consultation Form**

**Personal details**

Name

Address

Email

Doctor

Occupation

Have you received complementary therapies before?

Is there anything in particular that I may be able to help you with in terms of choosing the best essential oils for your treatment?

**Lifestyle**

Would you say you have a fairly balanced diet? Fruit/vegetables/nuts/seeds/fresh

Do you drink plenty of fluids?

How would you describe your stress levels currently? Low/medium/high

Do you suffer from anxiety? Yes/No low/medium/high

How would you describe your sleep pattern?

How are your energy levels? Low/medium/high

Do you partake in regular exercise? Yes/No

**Ladies further lifestyle questions**

Could you be pregnant? Yes/No (if no move on to the next section, if yes continue with this section)

No of weeks?

Did you conceive naturally? Yes/No

Have you experienced any complications with this or any other pregnancy? Yes/No

Do you have any other children?

Are you experiencing any discomfort?

Or general symptoms associated with being pregnant? Yes/No

Are you breast feeding? Yes/No

**Gynaecological**

|  |  |
| --- | --- |
| Do you know where you are in your monthly cycle? | Yes/No |
| What are your periods like? |  |
| Are your periods regular? ( monthly cycle) |  |
| Do you have any problems with your hormones generally? | Yes/No |
| **Medical** |  |
| Are you allergic to anything I need to be aware of? | Yes/No |
| Are you asthmatic? | Yes/No |
| Have you had a recent attack of Asthma? |  |
| Are you taking any prescribed medication? |  |
| Seasonal allergy problems, Sinusitis, Rhinitis, Tonsillitis |  |
| Do you have any heart conditions? | Yes/No |
| Is your blood pressure in the normal range of 120/80? | Yes/No |
| Do you suffer from Epilepsy? | Yes/No |
| Do you suffer from headaches or migraines? | Yes/No |
| Do you have any problems with digestion? | Yes/No |
| Do you suffer from any hormonal Imbalance problems? | Yes/No |
| Periods, Menopause, fertility problems, Thyroid  Problems? | Yes/No |
| Do you have any other circulatory problems or Swellings? | Yes/No |
| Do you suffer from any autoimmune conditions? | Yes/No |
| Have you had any serious illness in the past 3 years? | Yes/No |
| Do you have any muscular or skeletal conditions, aches or pains? | Yes/No |
| Is there anything else you think I need to know before Giving you a blend? Bruises, wounds | Yes/No |

Further observations

Essential oils chosen

Other products chosen

Dosage

Treatment

**Privacy notice protecting your personal data**

**All information provided on this form is totally confidential. No information provided or anything discussed will be shared with any other person or parties. This form will be kept in a secure place for only as long as is deemed necessary. More information is freely available on this policy by request.**

Client

I agree to the treatment plan offered and consent to the treatment suggested

Signed

.................................................................................

Date.............................

Please complete and email to emily@sulisaromatherapy.co.uk [mailto:emily@sulisaromatherapy.co.uk?subject=Client Consultation Form for Booking](mailto:emily@sulisaromatherapy.co.uk?subject=Client%20Consultation%20Form%20for%20Booking)