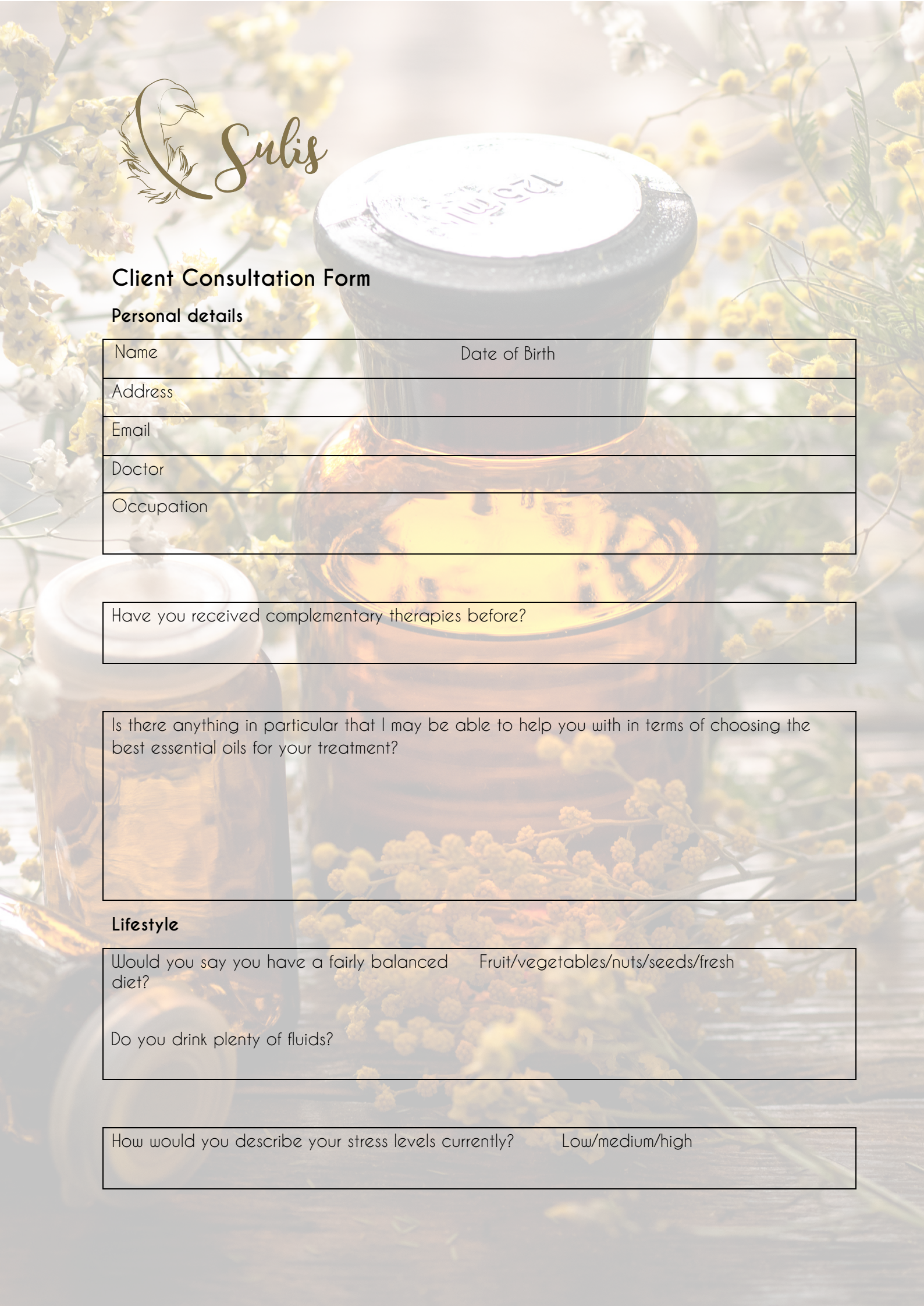

Sulis

Client Consultation Form

Personal details

Name	Date of Birth
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 health 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.

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

Date

Please complete and email to emily@sulisaromatherapy.co.uk