Client Intake Form

Name _____ Home # _____ Cell # _____

Address _____

Birth date _____ Occupation _____

Marital status _____ Children? _____ Ages _____

Last visit to **primary physician**? _____ Why? _____

Blood pressure reading _____/_____ Name of Primary Care Physician _____

Date of last **physical exam**? _____ **Height** _____ **Weight** _____

How is your **general health**? _____

Diagnosis (if any) from your doctor _____

Reason for today's visit? _____

General stress level ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

(no stress) (manageable stress) (unmanageable stress)

Comments _____

Exercise regularly? ◯ Yes ◯ No Frequency _____

Do you **smoke**? ◯ Yes ◯ No Frequency _____

Consume **caffeine**? ◯ Yes ◯ No Frequency _____

(Caffeine refers to coffee, tea, soft drinks, or any other caffeinated beverages)

Consume **diet soft drinks**? ◯ Yes ◯ No Frequency _____

Consume **alcohol**? ◯ Yes ◯ No Frequency _____

Eating habits (typical consumption on a normal day):

Breakfast _____

Mid-Morning Snack _____

Lunch _____

Afternoon Snack _____

Dinner _____

Bedtime Snack _____

Type of food normally eaten (indicate if seldom, moderately or heavily consumed):

Meat S M H	Fish S M H	Eggs S M H
Cheese S M H	Milk S M H	White Bread S M H
Raw Vegetables S M H	Fresh Fruits S M H	Potatoes S M H
Cooked Grains S M H	Fried Foods S M H	Chocolate S M H
Refined Sugar Products S M H	Malt S M H	Caramel S M H
Sweet Foods S M H	Salty Foods S M H	

Medical History

Surgeries/Serious Illness/Accident? _____ When? _____

Please describe what procedure(s) followed and when _____

_____

Nature of Injuries _____

Do you experience **headaches**? N Y Frequency? _____ **Migraines**? N Y Frequency? _____

What do you believe to be the cause of your headaches or migraines? _____

Average # hours of **sleep**? _____ Do you wake up at night? Y N If yes, how often? _____

How much time do you spend outdoors? _____ Doing what? _____

Activity level: ◯ Sedentary ◯ Moderate ◯ Very active

Time spent using a **computer/video games** each day _____ When? _____

Stomach or digestive complaints? _____

Reproductive/urinary complaints? _____

Other conditions you have been diagnosed with _____

_____

What **vitamins or supplements** are you taking? _____

_____

What **medications** (prescriptions) are you taking and for what condition(s)?

Medication/Dosage/Frequency _____ Reason _____

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Medication/Dosage/Frequency _____ Reason _____

Do you have any **allergies**? If so, please indicate _____

Check any that you experience more than once per week:

◯ Headache	◯ Fatigue	◯ Faintness/Dizziness	◯ Constipation
◯ Loose Bowels	◯ Excessive Urination	◯ Respiratory Problems	◯ Indigestion
◯ Cold Hands/Feet	◯ Stomach Upsets	◯ Nervousness	◯ Muscle Soreness
◯ Anxiety	◯ Chest Pains	◯ Heart Issues	◯ Poor Appetite
◯ Epilepsy	◯ Hepatitis	◯ Diabetes	◯ Blood Clots

◯ Tightness in the body, where? _____ ◯ Weakness in body, where? _____

◯ Immune Issues? Type? _____ ◯ Skin issues? Type? _____

Do you experience **pain**? ◯ Seldom ◯ Frequently ◯ Always Where? _____

Do you **exercise?** Y N Type _____ Frequency _____

Other or comments on above: _____

_____

For Women Only:

Are you trying to **conceive**? Y N Are you currently **pregnant**? Y N If yes, how far along are you? _____

What kind of birth control do you use? _____ Started menopause? Y N Finished? Y N

Do you suffer from PMS? Y N Please list any PMS symptoms? _____

For Men Only:

Do you suffer from prostate/erectile dysfunction? Complaints? _____

_____

Family History of Illness? Family member afflicted? _____

_____

Is there **anything else** I should be aware of that I have not already asked? _____

_____

Are there any scents you do not enjoy? (e.g. floral, citrus, camphor, etc.) _____

What outcome are you looking for as a result of your consultation? _____

_____

Please answer the above as honestly and accurately as possible, as it enables me to better serve your and create a blend and/or protocol specifically for you and your needs. The aim of the questionnaire is to identify causes of ill health and to assess the root cause of your *dis*-ease. Each blend is specific to each client's needs and not intended to be shared by family members and friends. Protocols will be created with your lifestyle in mind.

All information gathered in this intake form is private and confidential.

I acknowledge and confirm that:

- *I am of legal age and I am requesting a consultation from Lora Cantele, R.A.*
- *This consultation is for educational purposes and is not to diagnose or treat disease.*
- *I understand this consultation is not intended to replace medical care and I will seek medical treatment from a licensed health care provider, if required.*
- *I understand botanicals (including essential oils) may be contraindicated with certain health conditions. For this reason, I confirm that I have had a general physical exam from a medical doctor within the last 12 months and have disclosed any diagnosed conditions on the Client Information form.*
- *I understand that botanicals (including essential oils) can interact with prescribed medication. For this reason, I have disclosed all medications that I may be taking on the Client Information form.*
- *I will notify any healthcare provider of any essential oils, herbs, and/or dietary supplements that I may be taking.*
- *I understand Aromatherapy is not regulated by the Food & Drug Administration.*
- *I understand that no guarantees are made regarding the results from Aromatherapy or natural health methods, and that achieving wellness requires my commitment to my own good health, whether through diet, exercise or stress relief.*
- *I am under no obligation to follow any recommendations for lifestyle changes made by Lora Cantele, R.A.*

I understand Aromatherapy is not to be thought of as a cure for ailments, that Aromatherapy is a complementary means used to assist the body in healing itself. Also, that Aromatherapy is not meant to take the place of diagnosis or treatment by a qualified medical practitioner. I will seek medical treatment from a licensed healthcare provider if required. By signing below, I hereby state that, to the best of my knowledge, this intake form contains true, complete and correct information. The undersigned hereby releases and agrees to indemnify and hold harmless Lora Cantele, R.A./Enhancements Aromatherapy LLC from all claims of injuries, damages, losses, death, costs, and expenses of all kinds, including legal fees, in any way arising from or related to therapeutic interventions received at any time from Lora Cantele, R.A./Enhancements Aromatherapy LLC.

_____

Signature Date

Please return to: loracantele@gmail.com or mail to the address below

Lora Cantele, R.A. c/o Enhancements Aromatherapy LLC
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