



Client Intake Form

Name _____ Phone # _____ Home [] Cell [] Work []

Address _____

Birth date _____ Occupation _____

Marital status _____ Children? _____ Ages _____

Last visit to primary physician? _____ Reason? _____

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 seeking aromatherapy help? _____

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	Raw Vegetables	S	M	H	Refined Sugar Foods	S	M	H
Fish	S	M	H	Fresh Fruits	S	M	H	Malt	S	M	H
Eggs	S	M	H	Potatoes	S	M	H	Caramel	S	M	H
Cheese	S	M	H	Cooked Grains	S	M	H	Sweet Foods	S	M	H
Milk	S	M	H	Fried Foods	S	M	H	Salty Foods	S	M	H
White Bread	S	M	H	Chocolate	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? Yes No Frequency _____

Do you experience migraines? Yes No Frequency _____

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

Average # hours of sleep? _____ Do you wake up at night? Yes No 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: _____

Medication/Dosage/Frequency: _____ Reason: _____

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? Yes No Type _____ Frequency _____

Other or comments on above: _____

For Women Only:

Are you trying to conceive? Yes No

Are you currently pregnant? Yes No If yes, how far along are you? _____

What kind of birth control do you use? _____

Do you suffer from PMS? Yes No Please list any PMS symptoms? _____

Started menopause? Yes No Finished? Yes No

For Men Only:

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

Family History of Illness? Family member(s) afflicted? _____



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

Are there any scents you particularly enjoy? (e.g. floral, citrus, camphor, etc.) _____

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 you 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 products 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, RA.

I understand Aromatherapy is not a cure for ailments, that Aromatherapy is a complementary means used to assist the body in healing itself, and that an Aromatherapy consultation is not intended to replace the diagnosis or treatment by a qualified medical practitioner. I will seek medical treatment from a licensed healthcare provider if required.



Enhancements Aromatherapy LLC

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

[] I confirm that I have read and received a copy of the Client/Practitioner Roles

Please return to:

Lora Cantele, R.A.
c/o Enhancements Aromatherapy LLC
305 Homestead Parkway
Longmont CO 80504

Alternatively, you may scan and email to:

loracantele@gmail.com