Certified Aromatherapy Health Professional®
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Confidential Health History Form

Please complete all pages of this client intake form to the best of your ability for safety and accuracy, and so that your custom blend(s) will best suit your needs.

Name:

Address:

City: Postal code:

Home phone: Cell phone:

E-mail:

Preferred method of communication: E-mail ☐ / Text ☐ / Telephone ☐

Emergency contact:

Relationship: Phone:

Referred by:

Date of birth: Marital status:

Children: Ages:

Pregnant ☐ / Trying to conceive ☐ / Breastfeeding ☐ / NA ☐

Occupation: Full time ☐ / Part time ☐

Do you have a good support system? (family, friends, spouse, etc.)

Other relevant personal information:

Primary physician:

Other practitioners: DC ☐ / ND ☐ / TCM ☐ / RMT ☐ / Other:

List any recent and significant medical appointments:

Date	Reason for visit

List all prescriptions, OTC medications and supplements:

Name	Dosage/Frequency	Reason

Hospitalizations/Surgeries:

Date	Reason for visit

Do you get headaches? If so, how often and severe?

How do you relieve them?

What is your average stress level?

What do you do to relieve stress?

How many hours of sleep do you get a night? Do you wake rested?

Do you exercise? Activity: Frequency:

Do you drink alcohol? How much/often?

Do you smoke/chew tobacco? How much/often?

Do you use cannabis? How much/often?

Do you take any recreational drugs? How much/often?

Do you have any allergies? Medications ☐ / Airborne ☐ / Food ☐ / Contact ☐

If yes, please explain:

Are you on a special diet? If yes, please explain:

Do you have any digestive issues? Gas ☐ / Bloating ☐ / Heartburn ☐ / Other ☐

If other, please explain:

Bowel issues: Constipation ☐ / Diarrhea ☐ / Other ☐

If other, please explain:

Do you feel you go as often as you should? Frequency:

Urinary issues: Incontinence ☐ / Urgency ☐ / Frequent UTI ☐ / Other ☐

If other, please explain:

Menstrual issues: PMS ☐ / Heavy bleeding ☐ / Cramps ☐ / Other ☐

If other, please explain:

Skin condition: Dry ☐ / Rough patches ☐ / Cellulite ☐ / Acne-prone ☐ / Bruising ☐

Discoloration ☐ / Under-eye circles ☐ / Open sores ☐ / Rash ☐ / Other ☐

If other, please explain:

Are you under treatment or have you ever been treated for any of the following:

☐ Acne
☐ Arthritis
☐ Asthma
☐ Blood clots
☐ Cancer
☐ Chemical dependency
☐ Chronic fatigue
☐ Chronic pain
☐ COPD
☐ Crohn's
☐ Depression, anxiety
☐ Diabetes
☐ Eczema/Psoriasis
☐ Fibromyalgia
☐ Heart condition
☐ Hemophilia
☐ Hepatitis (A, B, C)
☐ Herpes
☐ High/low BP
☐ HIV/AIDS
☐ Lupus
☐ Multiple sclerosis
☐ Rheumatoid arthritis
☐ Scoliosis
☐ Seizures
☐ Stroke
☐ Varicose veins

Other:

How would you rate your general health overall?

Please provide any other relevant physical or mental health information:

Favourite scents:

Scents to avoid:

Previous aromatherapy experience/usage:

Essential oils/hydrosols you have at home:

What do you hope to achieve or change in terms of your health and wellness?
How can I help you as your aromatherapist?

Aromatherapy Release Form

I have stated all my known conditions and have answered all questions honestly.
I take it upon myself to keep the practitioner updated on my health.
I understand that the practitioner does not diagnose, prevent or cure illness, disease or any other physical or mental conditions.
I understand that this treatment is not a substitute for medical treatment, care and/or diagnosis, and it is recommended that I see a qualified professional for any physical or mental condition that I may have.

I understand the following:
I am not being advised to take any essential oil products internally.
I must keep all essential oil products out of the reach of children.
Essential oils could be poisonous if swallowed.
Essential oils must be stored in a cool, dark place.
Essential oils may irritate the skin if not stored or used properly.
Essential oils must be used with caution around animals.
Essential oils must be used with extreme caution for children under 5 years old.
I understand that all information I provide is strictly confidential.

I hold Shannon Bachorick, CAHP®, harmless for any injuries, reactions, illness or negative effects I may experience as a result of using essential oils or aromatic products.

Client Name (printed): ____

Client Signature: ____

Date: ________________________

Please return your completed form to shannonbachorick@myaccess.ca at least 24 hours before your appointment. Thank you!