World Vibrational Healing

Aromatherapy Client Intake Form

Full Name
Phone number
Mailing address
Email
Birthdate
Reason for visit: What is your primary concern?
Month/Year of onset of concern: Your idea of the cause:
What makes it feel better?
What makes it feel worse?
Are you pregnant? Trying to become pregnant? Are you breastfeeding?

Chronic Conditions (please check)
____ High Blood Pressure ____ Low Blood Pressure ____ Epilepsy ____ Any seizure disorder other than epilepsy ____ Allergies, please list:
Are you under the care of a physician? If so, please list the condition(s) you are being treated for:
Medications: Please list all medications, herbs and supplements you are taking:
Surgeries: Please list type and date of all surgeries:

Social History
Do you drink coffee? How many cups a day?
Do you drink alcohol? How much per day?
What are your daily activities?
How many hours a night do you sleep?

Pamala Gifford, QTTP, CA…..PO Box 653, Manchester, Wa. 98353
360-509-3230

Please provide any other information that you think we should know in order to treat you safely and effectively:
Aroma questions
Are there particular scents or aromas that disturb you?
Are there particular scents or aromas that you especially enjoy?
Do you have allergic reactions to any scents? If so, which ones:
Other concerns
Do you have other symptoms or concerns that have not been covered?

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