Client Consultation Form

**Therapist Details**

|  |  |
| --- | --- |
| **Course:** | AROMATHERAPY TREATMENT |
| **Centre name:** | BRIGHTON SCHOOL OF MASSAGE |
| **Learner (Therapist) name:** |  |

**Client Consultation Form**

|  |  |  |
| --- | --- | --- |
| **Client name/code** |  | |
| **Address** |  | |
| **Profession** |  | |
| **Telephone Number** | Mobile |  |
| Other |  |
| **Emergency Contact** | Name |  |
| Contact number |  |
| **Date of initial consultation** |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Personal details: | | | | | | |
| Age group | Under 18 🞏 | 18 – 29 🞏 | 30 – 39 🞏 | 40 – 49 🞏 | 50 – 59 🞏 | 60+ 🞏 |
| Gender |  | | | | | |
| GP Surgery and Address |  | | | | | |
| Last visit to the doctor |  | | | | | |

|  |  |  |
| --- | --- | --- |
| Medical History | | |
| Reason for treatment | |  |
| Muscular/Skeletal problems | | Back 🞏 Aches/pain 🞏 Stiff joints 🞏 Headaches 🞏  Notes: |
| Digestive problems | | Constipation 🞏 Bloating 🞏 Liver/gall bladder 🞏 Stomach 🞏  Notes: |
| Circulation | | Heart 🞏 Blood pressure 🞏 Fluid retention 🞏 Tired Legs 🞏 Varicose veins 🞏 Cellulite 🞏 Kidney problems 🞏 Cold hands and feet 🞏  Notes: |
| Gynaecological | | Irregular periods 🞏 P.M.T 🞏 Menopause 🞏 H.R.T. 🞏 Pill 🞏 Coil 🞏  Notes: |
| Nervous system | | Migraine 🞏 Tension 🞏 Stress 🞏 Depression 🞏  Notes: |
| Respiratory | | Allergies 🞏 Hay fever 🞏 Asthma 🞏  Notes: |
| Skin | | Dermatitis 🞏 Acne 🞏 Eczema 🞏 Psoriasis 🞏 Skin cancer 🞏  Notes: |
| Skin type | | Dry 🞏 Oily 🞏 Combination 🞏 Sensitive 🞏 Dehydrated 🞏  Notes: |
| Immune system | | Prone to infections 🞏 Colds 🞏 Sore throats 🞏 Chest 🞏 Sinus issues 🞏  Notes: |
| Medication taken | |  |
| Herbal remedies | |  |
| General health notes | |  |
| **Treatment Planning** | | |
| Treatment date and location |  | |
| Treatment plan / Application method |  | |
| Contraindicated oils / oils to avoid *include reason* |  | |
| Condition/s to treat and suitable essential oils | Condition:  Suitable essential oils: | |
| Condition:  Suitable essential oils: | |
| Condition:  Suitable essential oils: | |
| Essential oils selected | Oil:  Rationale: | |
| Oil:  Rationale: | |
| Oil:  Rationale: | |
| Carrier oil/s selected | Oil:  Rationale: | |
| Oil:  Rationale: | |
| Possible alternative oils |  | |
| Blend ratio  *include specific amounts of each essential and carrier oil used* | Body: | |
| Face: | |
| **Client signature**  *To be signed before treatment.* | Please sign here to agree with, and consent to, the proposed oil blend and confirm receipt of instructions for application.  Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Therapist Signature** | Please sign here to confirm information is correct.  Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |