Client Consultation Form

**Therapist Details**

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

**Client Consultation Form**

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

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| --- |
| 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 |  |

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| --- |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |