

## Aromatherapy Intake Form

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
First Last

Address: \_\_\_\_\_  
Street City State Zip

Phone: \_\_\_\_\_  
Home Work Cell

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1. How would you describe your overall health?
2. What are you hoping essential oils can do for your health?
3. Do you have any chronic illnesses?
  - If yes, what type of condition?
  - How long have you been aware of this condition?
  - What type of treatment(s) have you tried?
  - What has helped?
  - What symptoms are most difficult for you?

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4. Do you have any acute conditions you would like to address?
  
5. Please list any allergies:
  
6. Are you pregnant or trying to become pregnant?
  
7. Do you have epilepsy?
  
8. Do you have high/low blood pressure?
  
9. Which oils or aromas are you drawn to?
  
10. Do any oils or aroma's disturb you?
  
11. Are you under the care of a physician? If so, please list the condition(s) you are being treated for:
  
12. Please list any medications you are taking:

Since essential oils should not be used under certain circumstances, I affirm that I have truthfully answered all questions pertaining to my health on the Aromatherapy Intake Form. Please sign below.

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First name

Last name

Date