Healing Blue Bottle Wellness Center

Aromatherapy Consult Form

Name:_____ Date of Birth:_____

Phone:_____ Email:_____

Main Goal for Consult:_____

_____

_____

_____

Describe your physical health using 3-6 adjectives:

_____

Describe your emotional health using 3-6 adjectives:

_____

In what way could you improve your life: physically, emotionally, spiritually, and/or mentally:

_____

On a scale of zero (least) to ten (most), what is your average stress level:_____

How is the quality of your sleep on a scale of zero to ten? How many hours do you sleep deeply each night?_____

What is your favorite smell:_____

_____

What is your favorite childhood aroma?_____

Favorite Food:_____

Favorite Color(s):_____

What smells do you have an aversion to?_____

_____

Describe a recent activity that brought you joy/happiness/pleasure?_____

_____

_____

How do you want to feel when you wear your aromatherapy product?_____

_____

Previous and Current Relevant Medical History:

_____

_____

Therapist Notes:

_____

_____

_____

_____

_____