GIGIS AROMATIC APOTHECARIE LLC

Consultation Intake Form

Name Age Date

Address Phone

Main Wellness Concern: (list up to 3)

Your Idea of Causes:

Month/ Year of Onset:

List Symptoms/What makes it feel better: (ie: heat, ice, rest)

What makes it feel worse: (I.e. Exertion, cold, stress)

List Chronic conditions and any place you experience pain:

List areas of pain (either now or recurring)

High Blood Pressure: YES NO Diabetes: YES NO Low Blood Pressure: YES NO

Any Other Chronic Condition: YES NO If so please list:

List all Medications and if you take supplements:

Any History of Cancer? YES NO If yes please list:

Any Digestive issues? YES NO If yes please list:

Any Surgeries? YES NO if yes please list:

Any Lung Conditions? YES NO If yes please list:

Any Skin Conditions? YES NO If yes please list:

Any Chemical Sensitivities? YES NO If yes please list:

Any History of Anxiety or Depression? YES NO If yes please list:

Are you Pregnant? YES NO

What Life Stage are you in? Prepubescent [ ] Pubescent [ ] Perimenopausal [ ] Menopausal [ ] Post Menopausal [ ]

Aromatic preferences: scents you enjoy/ List any associations with the aroma:

Aromatic preferences: scents you dislike or find disturbing/List Association:

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Name: Age: Date:

Previous experiences with aromatherapy:

Experience with alternative healing modalities:

Lifestyle HIstory:

Exercise: Sedentary [ ] Mild Exercise [ ] Occasional Exercise (less than 4X/week) [ ] Regular exercise [ ]

List type of Exercise:

Sleep: How many hours of sleep do you usually get each night? Is it broken? Do you wake rested?

How would you describe your diet? Clean [ ] Some Processed Foods [ ] Mostly Processed Foods [ ] Eat Out/Fast Food [ ]

Caffeine: Do you drink caffeinated beverages? YES NO If yes how much?

Do you drink Alcohol? YES NO How much?

Do you use any form of tobacco or marijuana? YES NO How much?

Do you have pets in the house? YES NO If so, type:

Do you have children in the house? YES NO If so, ages:

Are you or is anyone in your house pregnant or breast feeding? YES NO

Do you have allergies? YES NO If so please list:

Are you under the care of a physician? YES NO If so, list conditions:

Do you have a preference on application method? TOPICAL INHALATION

Any questions or concerns? Any Information you think I should be aware of?