MASSAGE 4 LIFE, LLC
AROMATHERAPY INTAKE FORM

Name _____
Home # _____ Cell # _____
Address _____
_____
Birth date _____
Occupation _____
Marital status _____ Children? _____ Ages_____
Last visit to primary physician? _____
Why_____
Blood pressure reading _____/_____
Name of Primary Care Physician _____
Date of last physical exam? _____ Height _____
Weight _____
How is your general health?
_____
Diagnosis (if any) from your doctor
_____
Reason for today's visit?
_____
General stress level 1 2 3 4 5 6 7 8 9 10
(no stress) (manageable stress) (unmanageable stress)
Comments
_____
_____
Exercise regularly?
◯ Yes ◯ No Frequency _____
Do you smoke?
◯ Yes ◯ No Frequency _____
Consume caffeine?
◯ Yes ◯ No Frequency _____
(Caffeine refers to coffee, tea, soft drinks, or any other caffeinated beverages)

Consume diet soft drinks?
◯ Yes ◯ No Frequency _____
Consume alcohol?
◯ Yes ◯ No Frequency _____

Eating habits (typical consumption on a normal day):

Breakfast

_____

Mid-Morning Snack

_____

Lunch

_____

Afternoon Snack

_____

Dinner

_____

Bedtime Snack

_____

Type of food normally eaten (indicate if seldom, moderately or heavily consumed):

Meat S M H
Cheese S M H
Raw Vegetables S M H
Cooked Grains S M H
Refined Sugar Products S M H
Sweet Foods S M H
Fish S M H
Milk S M H
Fresh Fruits S M H
Fried Foods S M H
Malt S M H
Salty Foods S M H
Eggs S M H
White Bread S M H
Potatoes S M H

Medical History

Surgeries/Serious Illness/Accident? _____
When? _____
Please describe what procedure(s) followed and when

_____

_____

Nature of Injuries

_____

Do you experience headaches? N Y Frequency? _____
Migraines? N Y Frequency? _____ What do you believe to be the cause of your headaches or migraines? _____
Average # hours of sleep? _____ Do you wake up at night? Y N
If yes, how often? _____
How much time do you spend outdoors? _____
Doing what? _____
Activity level: ◯ Sedentary ◯ Moderate ◯ Very active
Time spent using a computer/video games each day _____
When? _____
Stomach or digestive complaints?

_____

Reproductive/urinary complaints?

_____

Other conditions you have been diagnosed with

_____

_____

What vitamins or supplements are you taking?

_____

_____

What medications (prescriptions) are you taking and for what condition(s)?
Medication/Dosage/Frequency _____
Reason _____
Medication/Dosage/Frequency _____
Reason _____
Medication/Dosage/Frequency _____
Reason _____
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Reason _____
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Reason _____
Medication/Dosage/Frequency _____
Reason _____

Do you have any allergies? If so, please indicate

_____

Check any that you experience more than once per week:

◯ Headache
◯ Loose Bowels
◯ Cold Hands/Feet
◯ Anxiety
◯ Epilepsy
◯ Fatigue
◯ Excessive Urination
◯ Stomach Upsets
◯ Chest Pains
◯ Hepatitis
◯ Faintness/Dizziness
◯ Nervousness
◯ Respiratory Problems
◯ Heart Issues
◯ Diabetes
◯ Constipation
◯ Indigestion
◯ Muscle Soreness
◯ Blood Clots
◯ Poor Appetite
◯ Tightness in the body, where? _____
◯ Weakness in body, where? _____
◯ Immune Issues? Type? _____
◯ Skin issues? Type? _____

Do you experience pain? ◯ Seldom ◯ Frequently ◯ Always

Where? _____

Do you exercise? Y N Type _____ Frequency _____

Other or comments on above:

_____

_____

For Women Only:

Are you trying to conceive? Y N Are you currently pregnant? Y N

If yes, how far along are you? _____

What kind of birth control do you use? _____

Started menopause? Y N Finished? Y N Do you suffer from PMS? Y N

Please list any PMS symptoms? _____

For Men Only:

Do you suffer from prostate/erectile dysfunction?
Complaints? _____
_____
Family History of Illness? _____
_____
Family member afflicted? _____

Is there anything else I should be aware of that I have not already asked?
_____
_____
_____
Are there any scents you do not enjoy? (e.g. floral, citrus, camphor, etc.)
_____

What outcome are you looking for as a result of your consultation?
_____
_____

Please answer the above as honestly and accurately as possible, as it enables me to better serve your and create a blend and/or protocol specifically for you and your needs. The aim of the questionnaire is to identify causes of ill health and to assess the root cause of your dis-ease. Each blend is specific to each client's needs and not intended to be shared by family members and friends. Protocols will be created with your lifestyle in mind.
All information gathered in this intake form is private and confidential.

I acknowledge and confirm that:

_____ I am of legal age and I am requesting a consultation from D.D. Willingham, C.A.
_____ This consultation is not to diagnose or treat disease.
_____ I understand this consultation is not intended to replace medical care and I will seek medical treatment from a licensed health care provider, if required.

_____ I understand botanicals (including essential oils) may be contraindicated with certain health conditions. For this reason, I confirm that I have had a general physical exam from a medical doctor within the last 12 months and have disclosed any diagnosed conditions on the Client Information form.
_____ I understand that botanicals (including essential oils) can interact with prescribed medication. For this reason, I have disclosed all medications that I may be taking on the Client Information form.
_____ I will notify any healthcare provider of any essential oils, herbs, and/or dietary supplements that I may be taking.

_____ I understand Aromatherapy is not regulated by the Food & Drug Administration.
_____ I understand that no guarantees are made regarding the results from Aromatherapy or natural health methods, and that achieving wellness requires my commitment to my own good health, whether through diet, exercise or stress relief.
_____ I am under no obligation to follow any recommendations for lifestyle changes made by D.D. Willingham, C.A.

I understand Aromatherapy is not to be thought of as a cure for ailments, that Aromatherapy is a complementary means used to assist the body in healing itself. Also, that Aromatherapy is not meant to take the place of diagnosis or treatment by a qualified medical practitioner. I will seek medical treatment from a licensed healthcare provider if required. By signing below, I hereby state that, to the best of my knowledge, this intake form contains true, complete and correct information. The undersigned hereby releases and agrees to indemnify and hold harmless D.D. Willingham, LMT, C.A./Massage 4 Life, LLC from all claims of injuries, damages, losses, death, costs, and expenses of all kinds, including legal fees, in any way arising from or related to therapeutic interventions received at any time from D.D. Willingham, LMT, C.A./Massage 4 Life, LLC.

_____

Signature Date