MY REMEDY

TAILOR MADE AROMATHERAPY BLENDS

CLIENT RECORD CARD

Name: _____ Date:_____

Address:_____

City, Country, Post Code:_____

Telephone- Home: _____ Work / Mobile:_____

E-mail:_____ Birth date:_____

Occupation:_____

Is there a possibility that you are pregnant? Yes __No __Are you nursing? Yes___ No ____

What are you current goals? What would you like to change or improve for your health / wellness?

_____

_____

GENERAL HEALTH AND LIFESTYLE

1: Do you exercise regularly? Yes___ No___ Type of exercise:_____

2: Do you experience any allergic reactions to any substances (food, environmental, etc)?_____

Yes___ No___ If yes, please describe:_____

3: Do you currently smoke? Yes___ No___ If yes, how many cigarettes per day?_____

How long have you smoked for? _____

Have you ever smoked? Yes___ No___

4: Do you drink any caffeinated drinks? Coffee, black tea, etc Yes___ No ___

If yes, how much do you drink in a day?_____

5: Rate you level of stress (10 being overwhelming and 1 being mild stress)

With work/school life:_____ With primary intimate relationships:_____

6: Do you have any specific spiritual practice? Please describe:_____

Do you have children? Children_____ Pregnancies_____

Is there a possibility of you being pregnant now?_____

How were you pregnancies? (It is of great importance whether the pregnancies were stable or unstable)

_____

_____

Have you ever had any major injuries or operations? (Entire life) _____

What happened? How was your recovery?_____

_____

Major illness which required hospitalisation? _____

Have you had a medical exam in the past year?_____

How was the testing?_____

Are you currently on medication? If yes, please list medication_____

_____

_____

Are you on blood thinners? (aspirin etc) _____

Do you suffer from high blood pressure? Yes___ No ___

What medication are you on? _____

Do you have heart problems? Yes___ No ___

What medication are you on? _____

Are you under the care of any other health care practitioner, traditional or orthodox?_____

_____

MEDICAL HISTORY

Please check any conditions that may apply to you. Also, please note next to each condition if either your parents or maternal or paternal grandparents had or have a history with any condition.

GENERAL:		**URINARY:**		**EARS, EYES, NOSE, THROAT**	
	Allergies		Excessive urination		Asthma
	Cancer		Water retention		Ear aches
	Dizziness				Eye pains, Dry/Wet
	Epilepsy	**WOMEN:**			Failing vision
	Fainting		Menopausal		Glaucoma
	Fatigue		Hot flashes		Sinus infection
	Headaches		Mood swings		Sore throat
	Mental disorder		Irregular cycle		Sinus congestion
	Nervousness		Breast lumps		
	Numbness		Infertility	**SKIN:**	
			Vaginal discharge		Boils
MUSCLES & JOINTS:			Lower back pain		Acne
	Arthritis		Venereal disease		Dryness (lacking oil)
	Backache/Upper				Dehydrated (lacking water)
	Backache /Lower	**CARDIOVASCULAR:**			Itching
	Broken bones		Heart attack		Varicose veins
	TMJ/Jaw pops		Heart disease		Inflamed/Sensitive
	Mobility limitations		High blood pressure		
	Spinal curvature		Low blood pressure	**RESPIRATORY:**	
	Sprained tendons/muscles		Pain in the heart area		Asthma
	Stiff neck		Poor circulation		Chest pain
	Swollen joints		Swelling of ankles/joints		Difficulty breathing
			Previous heart stroke		Dry cough
GASTROINTESTINAL:			Previous heart murmer		Spitting blood
	Belching				Congestion
	Constipation				
	Abdominal pain				
	Colitis				

RESPIRATORY SYSTEM:			
I am experiencing	Dry nasal/lung passages/cough	Burning/inflames lungs/nasal/coughs	Phlegm/ congestion/ wet cough
SKIN:			
Recently, my skin has been:	Dry, dry patches in difficult areas	Inflamed, heat, heat rashes, redness	Very oily

Any skin irritation, rashes, acne, boils, eczema, etc.? Please describe:

_____

_____

WEIGHT:			
I currently feel:	Underweight, have difficulty gaining	Losing and gaining weight easily	Overweight, difficulty losing it
TEMPERATURE:			
I feel:	Cold a lot	Hot and irritated	Cold and dull
SLEEP:			
I have been having:	Difficulty sleeping, wake up often and cannot fall back to sleep	Difficulty falling asleep, once asleep I sleep soundly	No problem sleeping, sleeping a bit excessively
EMOTIONAL WELLBEING:			
I feel:	Exhausted, restless, anxious, nervous	Tense, and tired but determined	Lethargic, low energy
	Indecisive, chaotic, difficulty focusing or concentrating	Judgmental, overly ambitious, negative	Uninspired, very resistant to change
STRESS:			
I have been feeling:	Tearful, anxious	Angry, aggressive, confrontational	Like I want to hide away
MENSTRUATION / MENOPAUSE:			
Regularity	Irregular/variable	Regular	Regular
Quality of flow	Light/variable	Heavy	Moderate/heavy
Emotions	Overwhelmed/anxious	Angry/irritable	Sluggish/Inertia

Informed Consent:

Aromatherapy is an incredible healing art and science that supports and enhances the individual's ability to heal and maintain health.

I understand that the consultation is designed to gather information so that my practitioner is able to design and create aromatic products based upon my unique needs and goals.

I understand that my aromatherapy practitioner, Anastasia Abela, does not diagnose, prevent of treat any illness, disease, or any other physical or mental condition.

I understand that this treatment is not a substitute for medical treatments and it is recommended that I see a qualified professional for any physical or mental condition that I may have.

This consultation does not take the place of a medical evaluation.

I have read the above information and I hereby give my permission to Janice Balzan to design an aromatic program for me based upon my unique needs and goals.

Client name:_____

Client signature:_____

Date:_____

TREATMENT 1:	
TREATMENT 2:	
TREATMENT 3:	
TREATEMENT 4:	
TREATMENT 5:	
TREATMENT 6:	