Client Consultation Form

iUCT22 – Aromatherapy

Centre name:	
Centre number:	
Learner name:	
Learner number:	
Date:	

Client name:		
Address:		
Profession:		
Telephone number:	Day:	
	Evening:	

Personal details:						
Age group:	Under 20 ☐	20 – 30 ☐	30 – 40 ☐	40 – 50 ☐	50 – 60 ☐	60+ ☐
Lifestyle:	Active ☐			Sedentary ☐		
Last visit to the doctor:						
GP Address:						
Number of children: *(If applicable)*						
Date of last period: *(If applicable)*						

Contra-indications requiring medical permission – *in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment (Select if/where appropriate):*					
Pregnancy (use only mandarin)	☐	Epilepsy	☐	Cancer	☐
Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)	☐	Recent operations	☐	Conditions causing muscular spasticity (e.g. cerebral palsy)	☐
Haemophilia	☐	Diabetes	☐	Kidney infections	☐
Any condition already being treated by a GP or another complementary practitioner	☐	Asthma	☐	Hormonal implants	☐
Medical oedema	☐	Any dysfunction of the nervous system (e.g. Multiple sclerosis, Parkinson's disease, motor neurone disease)	☐	Undiagnosed pain	☐
Osteoporosis	☐	Bell's palsy	☐	When taking prescribed medication	☐
Arthritis	☐	Trapped/pinched nerve (e.g. sciatica)	☐	Acute rheumatism	☐
Nervous/psychotic conditions	☐	Inflamed nerve	☐	Whiplash	☐
Cervical spondylitis	☐	Slipped disc	☐		

Contra-indications that restrict treatment – *(Select if/where appropriate):*					
Fever	☐	Pregnancy (abdomen)	☐	Hernia	☐
Contagious or infectious diseases	☐	Breast feeding	☐	After a heavy meal	☐
Under the influence of alcohol or recreational drugs	☐	Cuts	☐	Hypersensitive skin	☐
Diarrhoea and vomiting	☐	Bruises	☐	Sunburn	☐
Skin diseases	☐	Abrasions	☐	Scar tissues (2 years for major operation and 6 months for a small scar)	☐
Undiagnosed lumps and bumps	☐	Abdomen (first few days of menstruation depending how the client feels)	☐	Recent fractures (minimum 3 months)	☐
Localised swelling	☐	Haematoma	☐	Gastric ulcers	☐
Inflammation	☐	Varicose veins	☐		
* N.B. All known allergies should be checked. Client contra-indications should be checked against the safety data for each oil prior to treatment					

Written permission required by*(Either of which should be attached to the consultation form):*			
GP/Specialists	☐	Informed consent	☐

Personal information: (select if/where appropriate)									
Muscular/Skeletal problems:	Back ☐	Aches/pain ☐	Stiff joints ☐	Headaches ☐					
Digestive problems:	Constipation ☐	Bloating ☐	Liver/gall bladder ☐	Stomach ☐					
Circulation:	Heart ☐	Blood pressure ☐	Fluid retention ☐	Tired Legs ☐					
	Varicose veins ☐	Cellulite ☐	Kidney problems ☐	Cold hands and feet ☐					
Gynaecological:	Irregular periods ☐	P.M.T. ☐	Menopause ☐	H.R.T. ☐					
	Pill ☐	Coil ☐	Other:						
Nervous system:	Migraine ☐	Tension ☐	Stress ☐	Depression ☐					
Immune system:	Prone to infections ☐	Sore throats ☐	Colds ☐	Chest ☐	Sinuses ☐				
Regular antibiotic/ medication taken:									
Herbal remedies taken:									
Ability to relax:	Good ☐	Moderate ☐	Poor ☐						
Sleep patterns:	Good ☐	Poor ☐	Average no. of hours:						
Do you see natural daylight in your workplace?	Yes ☐	No ☐							
Do you work at a computer?	Yes ☐	No ☐	If yes how many hours:						
Do you eat regular meals?	Yes ☐	No ☐							
Do you eat in a hurry?	Yes ☐	No ☐							
Do you take any food/vitamin supplements?	Yes ☐	No ☐							
How many portions of each of these items does your diet contain per day?	Fresh fruit	Fresh vegetables	Protein and source:						
	Dairy produce	Sweet things	Added salt	Added sugar					
How many units of these drinks do you consume per day?	Tea	Coffee	Fruit juice						
	Water	Soft drinks	Other:						

Do you suffer from food allergies?	Yes ☐					No ☐			
Bingeing?	Yes ☐					No ☐			
Over eating?	Yes ☐					No ☐			
Do you smoke?	Yes ☐		No ☐		How many per day:				
Do you drink alcohol?	Yes ☐		No ☐		How many units per day:				
Do you exercise?	None ☐		Occasional ☐		Irregular ☐		Regular ☐		
	Type:								
What is your skin type?	Dry ☐		Oily ☐		Combination ☐		Sensitive ☐		Dehydrated ☐
Do you suffer/have you suffered from:	Dermatitis ☐		Acne ☐		Eczema ☐		Psoriasis ☐		
	Allergies ☐		Hay fever ☐		Asthma ☐		Skin cancer ☐		
Stress level	At work:				At home:				
Reason for treatment:									
Client profile:									
Treatment plan:									
Rationale for choice of each essential oil for each treatment:									
Rationale for choice of each carrier oil for each treatment:									
Alternative choice of oils for each treatment:									
Ratio of blending for each treatment:									

Details of how each treatment was conducted:	
How the client felt before the treatment:	
How the client felt during the treatment:	
How the client felt immediately after the treatment and immediate aftercare given:	
How the client felt between each treatment session:	
Specific home care advice for the treatment:	
Reflective practice:	
Overall conclusion:	

Therapist/learner signature: _____

Client signature: _____

Aromatherapy follow up sheet:	
Treatment plan:	
Rationale for choice of each essential oil for each treatment:	
Rationale for choice of each carrier oil for each treatment:	
Alternative choice of oils for each treatment:	
Ration of blending for each treatment:	
Details of how each treatment was conducted:	
How the client felt before the treatment:	
How the client felt during the treatment:	
How the client felt immediately after the treatment and immediate aftercare given:	
How the client felt between each treatment session:	
Specific home care advice for the treatment:	
Reflective practice:	
Overall conclusion:	

Date of treatment: _____

Document History

Version	Issue Date	Changes	Role
v1	09/10/2019	First published	Qualifications and Regulation Co-ordinator