Consultation Form

iUCT40 – Provide aromatherapy for complementary therapies

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):*					
Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)	☐	Recent operations	☐	Bell's palsy	☐
Haemophilia	☐	Diabetes	☐	Conditions causing muscular spasticity (e.g. cerebral palsy)	☐
Any condition already being treated by a GP or another complementary practitioner	☐	Asthma	☐	Kidney infections	☐
Medical oedema	☐	Any dysfunction of the nervous system (e.g. Multiple sclerosis, Parkinson's disease, Motor neurone disease)	☐	Hormonal implants	☐
Osteoporosis	☐	Trapped/pinched nerve (e.g. sciatica)	☐	Undiagnosed pain	☐
Arthritis	☐	Inflamed nerve	☐	When taking prescribed medication	☐
Nervous/psychotic conditions	☐	Pregnancy(use only mandarin)	☐	Acute rheumatism	☐
Whiplash	☐	Slipped disc	☐	Cervical spondylitis	☐
Chemotherapy	☐	Radiotherapy	☐	Postural deformities	☐
Epilepsy	☐	Cancer	☐		

Contra-indications that restrict treatment *(Select if/where appropriate):*					
Fever	☐	Cuts	☐	Abdomen(first few days of menstruation)	☐
Contagious or infectious diseases	☐	Bruises	☐	Haematoma	☐
Under the influence of recreational drugs or alcohol	☐	Abrasions	☐	Recent fractures(minimum 3 months)	☐
Diarrhoea and/or vomiting	☐	Scar tissue (2 years for major operation and 6 months for a small scar)	☐	Gastric ulcers	☐
Skin diseases	☐	Varicose veins	☐	Hernia	☐
Undiagnosed lumps and bumps	☐	Pregnancy (abdomen)	☐	Sunburn	☐
Localised swelling	☐	Breast feeding	☐	After a heavy meal	☐
Inflammation	☐	Hypersensitive skin	☐	Anaphylaxis	☐
Body piercing	☐				

- 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/specialist ☐	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 ☐	
	Sinuses ☐		Chest ☐	
Regular antibiotic/ medication taken?	Yes ☐	No ☐	If yes, which ones:	
Herbal remedies taken?	Yes ☐	No ☐	If yes, which ones:	
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 ☐	If yes, which ones?	
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 of these drinks do you consume per day?	Tea:	Coffee:	Fruit juice:	Water:
	Soft drinks:	Others:		
Do you suffer from food allergies?	Yes ☐		No ☐	
Bingeing?	Yes ☐		No ☐	
Overeating?	Yes ☐		No ☐	
Undereating?	Yes ☐		No ☐	
Do you smoke?	Yes ☐	No ☐	How many a day?	
	Other:			
Do you drink alcohol?	Yes ☐	No ☐	How many units a day?	
Do you exercise?	None ☐	Occasional ☐	Irregular ☐	Regular ☐
	Types:			
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 1–10 (10 being the highest):	At work ☐		At home ☐	

Client profile *(To include general lifestyle details):*

Treatment plan:

Rationale for choice of each essential oil/essence *(To include botanical names, plant families and significant chemical constituents):*

Rationale for choice of each carrier/fixed oil:

Alternative choice of oils:

Ratio of blending:

Client feedback:

Homecare advice *(detailing quantities of oils recommended/frequency and methods of use):*

Self-reflection and evaluation of the treatment:

Any CPD requirements *(to be completed on conclusion of treatment programme):*

Learner signature: _____

Client signature: _____

Continuation Sheet

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Client name:

Treatment date:

Treatment plan:

Rationale for choice of each essential oil/essence *(to include botanical names, plant families and significant chemical constituents) :*

Rationale for choice of each carrier/fixed oil:

Alternative choice of oils:

Ratio of blending:

Client feedback:

Home care advice *(detailing quantities of oils recommended/frequency and methods of use):*

Self-reflection and evaluation of the treatment:

Any CPD requirements *(to be completed on conclusion of treatment programme):*

Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	09/10/2019	First published	Qualifications and Regulation Co-ordinator
v2	10/01/2020	Re-published	Qualifications and Regulation Co-ordinator