

# BOTANICAL HEALING ARTS CLIENT ASSESSMENT FORM

Name \_\_\_\_\_ Street address \_\_\_\_\_  
City, state and zip \_\_\_\_\_  
Primary phone \_\_\_\_\_ Other phone \_\_\_\_\_ Email \_\_\_\_\_  
Date of birth \_\_\_\_\_ Occupation \_\_\_\_\_  
Physician \_\_\_\_\_ Last visit \_\_\_\_\_ Reason for visit \_\_\_\_\_

Existing medical conditions \_\_\_\_\_

Medications \_\_\_\_\_

Any history of serious illness or accidents?    Yes    No    If yes, describe

Describe any history of the following: heart problems, blood pressure, swelling, headaches (describe type, how often and duration), allergies, epilepsy, difficulty breathing, circulation, joint problems, digestive problems, menstrual( PMS or menopause), skin problems, back or neck problems or pain in any area.

Client's reason for aromatherapy consultation \_\_\_\_\_

On a scale of 1(minor) to 10(serious), how serious do you consider your problem?

Rate the following according to the effect on you. 1 is little or no effect; 10 is a serious problem.

Stress level                      Energy level                      Quality of sleep                      General Health

Is your weight average, over, or under for your age and build?

Do you have any emotional conditions you would like to address?

How are you feeling now?

What would you like the essential oils, blends or products to address?

Signature \_\_\_\_\_ Date \_\_\_\_\_

Mail this form with your check for \$45 to Botanical Healing Arts, 214 E. Newkirk St., Tuscola, IL 61953 or fax it with credit card information to 217 253-6760.