ABT Aromatherapy Intake Form

Date of Intake:

Client Number or Nickname:	**Age**:
Occupation:	**Gender**:

REASON FOR VISIT	
What is your primary concern?	**Month/Year of onset**:
Your idea of the cause:	
What makes it feel better?	
What makes it feel worse?	

HEALTH HISTORY		
Chronic Conditions:	[ ] High Blood Pressure	[ ] Low Blood Pressure
	[ ] Diabetes	[ ] Seizure Disorder
	[ ] Other Chronic Conditions:	
Do you have any allergies? If so, list below.		
Are you under the care of a physician? If so, list conditions you are being treated for below.		
Prescribed medications, over-the-counter drugs, vitamins, herbs, and supplements:		

Surgeries:	
Year	Type of Surgery

Do you have asthma or any lung conditions?	[ ] Yes	[ ] No
Are you experiencing any skin conditions?	[ ] Yes	[ ] No
Are you currently undergoing any treatment for cancer?	[ ] Yes	[ ] No
Do you have multiple chemical sensitivity?	[ ] Yes	[ ] No
Are you pregnant?	[ ] Yes	[ ] No
Are you trying to become pregnant?	[ ] Yes	[ ] No
Are you breastfeeding?	[ ] Yes	[ ] No

SOCIAL HISTORY			
Exercise	[ ] Sedentary (No exercise)		
	[ ] Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	[ ] Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	[ ] Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Sleep	How many hours of sleep do you usually get per night?		
Caffeine	[ ] No	[ ] Yes	
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?	[ ] Yes	[ ] No
	How many drinks per week?		
Tobacco	Do you use tobacco?	[ ] Yes	[ ] No
Other Drugs	Do you currently use recreational drugs?	[ ] Yes	[ ] No
Others in the Home	Are there pets in the house? If so, type(s):	[ ] Yes	[ ] No
	Are there children in the house? If so, ages:	[ ] Yes	[ ] No
	Is there a pregnant person in the house?	[ ] Yes	[ ] No
	Are there elderly people in the house?	[ ] Yes	[ ] No

OTHER INFORMATION

Any other information you think we should know in order to work with you safely and effectively:

AROMATIC PREFERENCES
Are there particular aromas or scents that disturb you? If so, list below.
Are there particular aromas or scents that you especially enjoy? If so, list below.

OTHER CONCERNS
Do you have other symptoms or concerns that have not been covered?