

Aromatherapy Client Record

Name: _____ Email: _____

Phone: _____ Mobile: _____

Address: _____

Occupation: _____ Date of Birth: _____

MEDICAL HISTORY

Current medication: _____

Serious illnesses: _____

Operations / broken bones: _____

Muscular / skeletal systems: _____

Circulatory system: _____

Respiratory system: _____

Digestive system: _____

Skin: _____

Menstrual cycle length: _____ days Heavy / Regular / Light

Date of last periods: _____

Sleeping habits: _____

Stress / emotional: _____

Consultation date: _____ Client signature: _____