NB Naturals Professional Aromatherapy
Kate Murray-Fuerth, B.A., CAP
Office: (519) 772-0292
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NEW CLIENT INTAKE FORM

Name: _____

Date of Birth: _____ Age:_____

E-mail: _____ Phone: _____

Address: _____

Occupation: _____

Family Doctor: _____ Phone: _____

Referred by: _____

Primary Concern(s):

SKIN CARE	**MENTAL HEALTH**	**PHYSICAL HEALTH**
☐ Dry Skin	☐ Stress	☐ Nausea
☐ Oil Skin	☐ Anxiety	☐ Muscle pain
☐ Acne	☐ Depression	☐ Headaches
☐ Eczema	☐ Insomnia	☐ Menstrual pain
☐ Psoriasis	☐ Other	☐ Menopause
☐ Other		☐ Other

If you checked 'Other', please describe:

_____
_____
_____
_____
_____
_____

Have you ever seen an Aromatherapist before? ☐ YES ☐ NO

Are you currently pregnant: ☐ YES ☐ NO

Have you been diagnosed with or treated for high blood pressure: ☐ YES ☐ NO

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Have you been diagnosed with or treated for any type of cancer: ☐ YES ☐ NO

Please list any previous injuries or accidents:

1. _____ DATE: _____
2. _____ DATE: _____
3. _____ DATE: _____

Please list any previous surgeries:

1. _____ DATE: _____
2. _____ DATE: _____
3. _____ DATE: _____

Please list any medications taken in the last 6 months:

1. _____ DATE: _____
2. _____ DATE: _____
3. _____ DATE: _____

Please check any physical conditions you have experienced or are currently experiencing:

CARDIOVASCULAR
☐ High blood pressure
☐ Low blood pressure
☐ Heart disease
☐ Heart attack
☐ Stroke
☐ Varicose veins
☐ Pacemaker

RESPIRATORY
☐ Chronic cough
☐ Bronchitis
☐ Asthma
Do you smoke: ☐YES ☐NO

INFECTIONS
☐ Herpes

SKIN
☐ Eczema
☐ Psoriasis
☐ Acne

DIGESTIVE/ Urinary
☐ Constipation
☐ Diarrhea
☐ Liver problems
☐ Kidney problems
☐ Bladder infection

HEAD & NECK
☐ Headache
☐ Migraine

WOMEN
☐ Menstrual pain
☐ Menopausal concerns
☐ Pregnant
Due date: _____
# of children: _____

MUSCLE/JOINT
☐ Muscle strain
☐ Sprains
☐ Arthritis (OA or RA)

OTHER
☐ Diabetes
☐ Allergies:
_____
☐ Cancer
☐ Epilepsy
☐ Car accident

OTHER HEALTH CARE
☐ Chiropractor
☐ Acupuncture
☐ Medical Doctor
☐ Physiotherapist
☐ Naturopath
☐ Osteopath
☐ Other

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***For Aroma-Health clients only** (if you are a skincare client, please use the next page to fill out the food journal)

SLEEP JOURNAL:
For one week prior to your first appointment, please try to fill out the following sleep journal:

DAY/ Time to bed	# of Times Waking in the Night	Amount of time awake in the night	Time to get up	Please rate your overall quality of sleep (1 being the worst it could be, 10 being the best it could be)
DAY ONE Time:			Time:	
DAY TWO Time:			Time:	
DAY THREE Time:			Time:	
DAY FOUR Time:			Time:	
DAY FIVE Time:			Time:	
DAY SIX Time:				
DAY SEVEN Time:				

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FOOD JOURNAL

***For Skincare clients only** (*if you are an aroma-health client, please fill out the Sleep Journal*)

FOOD JOURNAL:
For one week prior to your first appointment, please try to fill out the following food journal:

DAY	BREAKFAST	LUNCH	DINNER	SNACKS

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