Consultation Form

Cotswold Academy Complementary health & sport iTEC

Unit 382/iUCT40 - Aromatherapy Treatments

College Name: **Cotswold Academy**

College Number: **X1107**

Student Name:

Client Name:

Profession:

GP Address:

Last visit to the doctor:

PERSONAL DETAILS:

Age group: Under 20 ☐ 20-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60+ ☐

Lifestyle: Active ☐ Sedentary ☐ Both ☐

No. of children (if applicable):

Date of last period (if applicable:)

CONTRAINDICATIONS that require medical permission *(select if/where appropriate):*

- ☐ Pregnancy (only use Mandarin)
- ☐ Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)
- ☐ Haemophilia
- ☐ Any condition already being treated by a GP or another health professional, e.g. Physiotherapist, Osteopath, Chiropractor, Coach
- ☐ Medical oedema
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Anxiety/stress/depression
- ☐ Epilepsy
- ☐ Recent operations
- ☐ Diabetes
- ☐ Asthma
- ☐ Any dysfunction of the nervous system e.g. Multiple sclerosis, Parkinson's disease, Motor neurone disease
- ☐ Bell's Palsy
- ☐ Trapped/Pinched nerve (e.g.sciatica)
- ☐ Inflamed nerve
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiotherapy
- ☐ Cervical Spondylitis
- ☐ Spinal cord conditions (e.g.cerebral palsy)
- ☐ Kidney infections
- ☐ Whiplash
- ☐ Slipped disc
- ☐ Hormonal Implants
- ☐ Undiagnosed pain
- ☐ Acute rheumatism
- ☐ Thyroid Disorders
- ☐ Postural Deformities
- ☐ Severe Allergies (that require medical attention e.g. nuts)
- ☐ Taking prescribed medication

Please give details of any other diagnosed medical condition that is not listed above:

CONTRAINDICTIONS THAT RESTRICT TREATMENT *(select if/where appropriate):*

- ☐ **Fever**
- ☐ **Contagious or infectious diseases**
- ☐ **Under the influence of recreational drugs or alcohol**
- ☐ **Diarrhoea and vomiting**
- ☐ Pregnancy (abdomen)
- ☐ Breast feeding
- ☐ Skin diseases
- ☐ Undiagnosed lumps or bumps
- ☐ Localised swelling
- ☐ Inflammation
- ☐ Body piercing
- ☐ Varicose veins
- ☐ Cuts ☐ Bruises ☐ Abrasions
- ☐ Scar tissue (2 years for major operation and 6 months for a small scar)
- ☐ Sunburn
- ☐ Hormonal Implants
- ☐ Menstruation (first few days- abdomen)
- ☐ Haematoma
- ☐ Recent fractures (min 3 months)
- ☐ Hypersensitive skin
- ☐ Anaphylaxis
- ☐ Gastric ulcers
- ☐ After a heavy meal

WRITTEN PERMISSION REQUIRED BY GP/SPECIALIST *(If any of the boxes above are ticked, a disclaimer form should be completed by the client and attached to the consultation form):*

Yes ☐ No ☐

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 ☐ Chest ☐ Sinuses ☐

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. hours: ☐

Do you see natural daylight at work? 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: ☐

What do you eat for…
Breakfast: ☐
Lunch ☐
Dinner: ☐

Do you eat (regularly): Sweet things: ☐ Added salt: ☐
Added Sugar: ☐

Do you restrict any food groups? Yes ☐ No ☐
If so, what? ☐

How many units of drinks do you consume per day?

Tea: ☐ Coffee: ☐ Fruit juice: ☐ Water: ☐
Soft Drinks: ☐ Other: ☐

Do you suffer from food allergies? Yes ☐ No ☐
If yes, what? ☐

Does stress affect your eating habits? Yes ☐ No ☐
If so, how? ☐

Do you smoke? Yes ☐ No ☐ How many per day? ☐

Do you drink alcohol? Yes ☐ No ☐ Units per week? ☐

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 ☐

Do you suffer from allergic skin reactions? Yes ☐ No ☐
If so, to what? ☐

Stress level: 1–10 (10 being the highest)
At work ☐ At home ☐

Right handed ☐ Left handed ☐

CLIENT PROFILE/LIFESTYLE *(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:

HOME CARE/AFTERCARE ADVICE *(detailing quantities of oils recommended/frequency and methods of use):*

CLIENT FEEDBACK:

SELF-REFLECTION AND EVALUATION OF THE TREATMENT (this field to be completed **for case studies only**):

HOW YOUR INFORMATION WILL BE USED

I take your privacy very seriously; your personal information will only be used for treatment purposes and will never be shared with any third parties, without express permission.

KEEPING IN TOUCH

From time to time, I would like to get in touch with you when I have information about new therapies and special offers that I think might be of interest to you. If you agree to being contacted in this way, please tick how you are happy to be contacted:

O Post O Email O Phone O SMS

If you have ticked one or more of the boxes above, please note that you can change your preferences or remove your consent at any time by getting in contact with me.

By signing below, you agree that your medical history is accurate and correct, and you agree to all the above statements.

Client's Signature

Learner/Therapist Signature

Date

Treatment Continuation

Cotswold Academy Complementary health & sport iTEC

Unit 382/iUCT40 - Aromatherapy Treatments

TREATMENT NO:

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:

HOME CARE/AFTERCARE ADVICE *(detailing quantities of oils recommended/frequency and methods of use):*

CLIENT FEEDBACK:

SELF-REFLECTION AND EVALUATION OF THE TREATMENT (this field to be completed **for case studies only**):

ANY CPD REQUIREMENTS (this field to be completed **for case studies only on conclusion of treatment programme**):

Client's signature

Learner/Therapist signature