

iUCT40 - Aromatherapy Treatments

Case Study No: Treatment No:

College Name:

College Number:

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):*

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

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

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

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

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):

DISCLAIMER/INFORMED CONSENT (select if/where appropriate):

I confirm that I have understood the treatment that I am to receive and confirm that I am willing to proceed without confirmation from my own GP or Consultant.

You should note that if the student/therapist is unable to explain to you the contra indications or is unsure of anything that may apply to a specific condition then they should not treat you without asking you to consult with your GP or Consultant.

It is **your responsibility** and not that of the student/therapist to consult your GP or Consultant.

By signing this form below, I hereby indemnify the student/therapist against any adverse reaction sustained as a result of the treatment.

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:

- Post Email Phone 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's/Therapist Signature

Date

iUCT40 - Aromatherapy Treatments

Client Name:

CASE STUDY NO: TREATMENT NO:

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:

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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