

Client History Form

NAME: _____ DATE OF BIRTH: _____
 ADDRESS: _____ REFERRED BY: _____
 EMAIL: _____ OCCUPATION: _____
 PHONE: _____ (mob) _____ (hm) _____ (wk)

To offer you the best possible session, and to ensure that I use the correct types/quantities of essential oil for your body, it's important I know your medical history. Please complete all questions below, and provide any additional relevant information:

<p>IMPORTANT SAFETY Q's</p> <p><input type="checkbox"/> I am on medication for thinning the blood (Aspirin, Heparin, Warfarin, etc)</p> <p><input type="checkbox"/> I have high blood pressure</p> <p><input type="checkbox"/> I may be pregnant</p> <p><input type="checkbox"/> I have had an epileptic seizure. If so, When was your last seizure?..... Frequency of seizures?.....</p> <p><input type="checkbox"/> I am under 5 years of age</p> <p><input type="checkbox"/> I am under 18 months of age</p> <p><i>If any of the above boxes are ticked, the Essential Oils Desk Reference Appendices are consulted for oils to avoid or use with caution</i></p> <p><input type="checkbox"/> I have a <u>current</u> blood clot/s</p> <p><i>Raindrop Technique must not be performed if current blood clots. EECT may be performed without any bodywork (anointing only)</i></p> <p><input type="checkbox"/> I am allergic to nuts. If so, the oils which I know I am safe to use are:</p> <p><input type="checkbox"/> Olive <input type="checkbox"/> Rice Bran <input type="checkbox"/> Sesame <input type="checkbox"/> Safflower/Sunflower <input type="checkbox"/> Almond <input type="checkbox"/> Coconut <input type="checkbox"/> Jojoba <input type="checkbox"/> Other.....</p> <p><i>The Essential Oils Desk Reference Appendices indicates which essential oil blends contain nut oils. If you are allergic to these oils, a different oil will be used in its place. eg. Valor Roll On (with coconut oil) in place of Valor; One of your "safe" oils in place of V6.</i></p> <p><input type="checkbox"/> I have synthetic/plastic parts in my body (eg. pacemaker, breast implants). Details:.....</p> <p><i>Essential Oils should not be applied directly over plastic parts in the body (10cm clearance)</i></p> <p>BACK/NECK PAIN</p> <p><input type="checkbox"/> I am NOT able to lie on my back or stomach for up to one hour. <i>You may sit in a chair or lie on your side for all/part of the session</i></p> <p><input type="checkbox"/> I have a current/past back or neck problem including injury/operation to my spine? Please describe:</p> <p><i>Caution is exercised when working near the site of the injury. If injury is current, Raindrop Technique will be performed down the spine.</i></p>	<p>CHEMICAL EXPOSURE</p> <p><i>If significant exposure has occurred, your session may be modified to avoid major detox symptoms</i></p> <p><input type="checkbox"/> I am a smoker. How many cigarettes a day?.....</p> <p><input type="checkbox"/> I regularly drink alcohol How many glasses a week?.....</p> <p><input type="checkbox"/> I drink fewer than 8 glasses of water a day (not counting other beverages). How many glasses per day?.....</p> <p><input type="checkbox"/> I've had significant chemical exposure through my profession, hobbies, environmental exposure, recreational or prescription drugs. Please provide details:</p> <p>Which apply to you <u>in the past 12 months</u>:</p> <p><input type="checkbox"/> Been vaccinated <input type="checkbox"/> Taken antibiotics <input type="checkbox"/> Taken antidepressants <input type="checkbox"/> Taken synthetic hormones-IVF, HRT, contraceptive pill) <input type="checkbox"/> Had a general anaesthetic <input type="checkbox"/> Had amalgams removed from teeth <input type="checkbox"/> Undergone chemo/radiation therapy <input type="checkbox"/> Had my hair coloured <input type="checkbox"/> Been on pharmaceutical medication</p> <p>IN THE PAST 12 MONTHS:</p> <table border="0"> <tr> <td><input type="checkbox"/> Acne (severe)</td> <td><input type="checkbox"/> Diabetes</td> </tr> <tr> <td><input type="checkbox"/> Allergies</td> <td><input type="checkbox"/> Glandular Fever</td> </tr> <tr> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Ross River Fever</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Heart Attack</td> </tr> <tr> <td><input type="checkbox"/> Autoimmune disease</td> <td><input type="checkbox"/> Herpes</td> </tr> <tr> <td><input type="checkbox"/> Bacterial Infection</td> <td><input type="checkbox"/> Lupus</td> </tr> <tr> <td><input type="checkbox"/> High Blood Pressure</td> <td><input type="checkbox"/> Mental Illness</td> </tr> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Migraines</td> </tr> <tr> <td><input type="checkbox"/> Candida/Thrush</td> <td><input type="checkbox"/> Parkinsons/M.S.</td> </tr> <tr> <td><input type="checkbox"/> Chronic Fatigue</td> <td><input type="checkbox"/> Shingles</td> </tr> <tr> <td><input type="checkbox"/> Recurring Cystitis</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td><input type="checkbox"/> Depression</td> <td><input type="checkbox"/> Viral infection</td> </tr> <tr> <td><input type="checkbox"/> Dermatitis/Eczema/Psoriasis/Rosacea</td> <td></td> </tr> </table> <p>List other current illnesses/allergies:</p> <p><i>Specific essential oils may be included in Raindrop Technique to assist your overall health</i></p>	<input type="checkbox"/> Acne (severe)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Allergies	<input type="checkbox"/> Glandular Fever	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Ross River Fever	<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Herpes	<input type="checkbox"/> Bacterial Infection	<input type="checkbox"/> Lupus	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Candida/Thrush	<input type="checkbox"/> Parkinsons/M.S.	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Shingles	<input type="checkbox"/> Recurring Cystitis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Depression	<input type="checkbox"/> Viral infection	<input type="checkbox"/> Dermatitis/Eczema/Psoriasis/Rosacea		<p>SPECIFIC CONDITIONS</p> <p><input type="checkbox"/> I have Multiple Sclerosis</p> <p><input type="checkbox"/> I am a Quadraplegic</p> <p><i>If either of these 2 boxes are ticked, Raindrop Technique will be performed down the spine.</i></p> <p><input type="checkbox"/> I like hot drinks- no cool water added</p> <p><input type="checkbox"/> I strongly dislike cold weather</p> <p><input type="checkbox"/> I strongly dislike cold showers and swimming in cold water</p> <p><i>If 2 or 3 of these boxes are ticked, less Peppermint oil is used in Raindrop Technique</i></p> <p><input type="checkbox"/> I have a current skin rash/skin lesions Where?..... <i>Essential oils may cause irritation if applied to broken skin</i></p> <p><input type="checkbox"/> I have taken/am taking antidepressants</p> <p><input type="checkbox"/> Describe your current emotional state:</p> <p><i>Specific essential oils may be included in your session to benefit your emotional state</i></p> <p>OPERATIONS/MEDICATION</p> <p>Please list <u>all</u> operations (and year):</p> <p>.....</p> <p>List current pharmaceutical medications</p> <p><i>Certain medications may be enhanced or inhibited by the use of essential oils. Please check with your doctor before your session.</i></p> <p>HEALTHY LIFESTYLE</p> <p>In the past 12 months I have:</p> <p><input type="checkbox"/> Been on a detox regime</p> <p><input type="checkbox"/> Used Young Living's products daily</p> <p><input type="checkbox"/> Received Raindrop Technique</p> <p><input type="checkbox"/> Received Egyptian Emotional Clearing</p> <p><input type="checkbox"/> Exercised regularly</p> <p><input type="checkbox"/> Used the following natural therapies:</p> <p>MY SESSION GOALS ARE:</p>
<input type="checkbox"/> Acne (severe)	<input type="checkbox"/> Diabetes																											
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