Health History Questionnaire

Name_____ Date_____

Home Phone _____ Mobil _____

Email_____BD_____

Address_____

Last Physical Exam_____ Height_____ Weight_____ Desired _____

In Case of Emergency _____

Physician Name and Phone #_____

MEDICAL HISTORY

Blood Pressure _____

Heart Ailment _____Chest Pains _____ Palpitations _____ Dizzy_____

Family History _____

_____

Allergies: Food/Mold/Hay-Fever_____

_____

Metabolic Disorders/Obesity _____ Bulimic _____Swelling (water retention) _____

Diabetes 1 or 2 _____ Hypo/Hyperglycemia _____

Cholesterol _____Anemic_____

Bone/Joints/Tendons/Arthritis_____

Back/Neck/Shoulders Pains_____

Lungs _____ Cough _____Shortness of Breath_____

_____

Chronic Infections-Lungs/Tonsilitis/Yeast/_____

_____

Skin/ Exzema/Acne/Dry_____

Kidney/Stones/Urinary Tract_____
_____

Bowel Movements/Colon/Digestion_____
_____

Acid Reflux/Heart Burn/Upset Stomach_____
_____

Emotional and Mental-Depression _____ Anxiety Attacks _____ Nervous _____

Cry Easily _____ Anger _____ Irritable _____ Mourning _____ Bi-Polar_____
ADD_____ ADHD _____

Sleep Habits Insomnia _____ Average Hours Sleep Nightly _____

What type of treatment(s) have you tried? _____
_____

What has helped? _____
_____

What symptoms are most difficult for you? _____
_____

Do you have any acute conditions you would like to address? _____
_____

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Which oils/aromas are you drawn to? _____
_____

Do any oils or aromas disturb you? _____
_____

Do you have any allergic reactions to any scents/flowers/trees? _____ If so, which ones:
_____

Are you allergic to any foods? _____

Are you under the care of a physician? _____ If so, please list the conditions you are being treated for: _____
_____

Relationships - Scale of 1 (lowest) - 5 (highest)

Mother	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Father	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sisters	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Brothers	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Significant Other	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Children	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Grandparents	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
In-laws	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Friends	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Other	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Exercise Program/Golf/Tennis/Aquatics/Cardio/Strength Train/Walk/Jog/Gardening/Outdoor Activities_____
_____
_____
_____

Occupations (include Parenting and how many children) Hours per day ___ Hours per week ___
_____
_____
_____

Medications Prescription and Over the Counter: _____
_____
_____
_____
_____

Previous History of Health include accidents/auto/activity/hiking/sports related:
_____
_____
_____
_____

Self-Healing and Medication: _____
_____
_____
_____
_____

Essential Oils Coaching is a holistic science-art that utilizes concentrated plant extracts in the form of essential oils to bring harmony and balance to the body, mind, and spirit.

I understand that this consultation is designed to gather information so that my Essential Oils Coach is able to create a customized treatment plan for my unique goals and needs.

I understand that my Essential Oils Coach, Sondra Spracklen, is not a doctor and does not diagnose or treat for a specific illness nor does she prescribe or adjust medication.

I understand that Essential Oils Coaching is a great compliment to most types of therapy. I affirm that I have completed this intake form accurately and honestly, and agree to notify Sondra Spracklen of any changes that may affect my health profile.

I understand that all my information is strictly confidential. If at any time I need my Essential Oils Coach to discuss my case with another practitioner I may request so in writing. By signing this form, I give my consent to an Essential Oils Consultation and Customized Treatment Plan. I acknowledge that I have read and understand the information below. If I have been diagnosed by a licensed health professional as having any disease, injury, or other physical or mental condition, I understand that I should inform the person who made the diagnosis, about the services I will be receiving, and whether or not I intend to discontinue any treatment or therapy which had been previously ordered, prescribed, or recommended by a licensed health professional. I understand that by discontinuing any such treatment or therapy I agree to hold Good Vibrations Health Studio free from any liability, assuming my personal responsibility for any negative outcome resulting from discontinuing that treatment or therapy.

Client Signature _____ Date: _____

Essential Oils Coach Signature _____