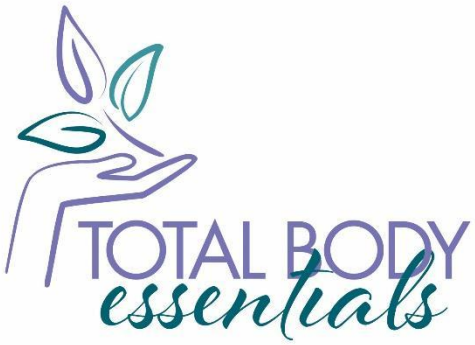
Intake Assessment Form



Date _____

Name _____Age _____

Address _____

Phone _____ Occupation _____

Email _____

Permission to Email you for upcoming events or other related information? Yes ____ No _____

Living Situation (alone, with pets, etc.) _____

_____

Experience with Essential Oils, Energy Medicine, or other related _____

Surgeries (What kind? When?) _____

Physical Limitations? _____

Accidents _____

Are you currently experiencing any pain? Where? _____

Medications, Supplements, Herbs, etc. _____

_____

Allergies/Sensitivities _____

Sleep (hours/night) _____ Any challenges? _____

Exercise (how much/kind) _____

Stress (0=low 10=high) Personal _____ Work _____

Stress Reduction/Relaxation Techniques _____

Meditation/Spiritual Practices _____

Goals (Health/Life) _____

Emergency Contact _____

What is your reason for coming today? _____

_____

Rating Scale: 0-5	
Anxiety _____	_____
Pain _____	_____
Stress _____	_____