Today's Date: _____

GaiaScent

Diane Bryson, CCA

Health History Questionnaire

Please help us provide you with a complete evaluation by taking time to fill out this questionnaire carefully. All answers are confidential. If there is anything you wish to bring to our attention, please note it in the comments section. Thank you.

Name: _____ Date of Birth: _____
Home Phone: _____ Mobile Phone: _____
Occupation: _____Work Phone: _____
Marital Status: _____ Height: _____ Weight: _____

Have you tried aromatherapy before? _____

Main problem(s) you would like to address: _____
_____
When did you first notice these symptoms_____
What extent does this problem affect your daily activities (work, sleep, eating exercise)_____
_____
_____
_____
Has your physician given you a diagnosis? _____ What is the diagnosis: _____
What kind of treatment, therapy, or medications have you tried for this problem? _____
_____
_____
Additional Information_____
Blood Type _____

Past Medical History

_____ Asthma	_____ Epilepsy	_____Pacemaker	_____ Other
_____ Cancer	_____ Blood Clots	_____Diabetes	
_____ Hypoglycemia	_____ High Blood Pressure	_____High Cholesterol	
_____ Rheumatic fever	_____ Low Blood Pressure	_____Thyroid Disease	
_____ Heart Disease	_____ Phlebitis	_____Seizures	
_____ Hepatitis	_____ GI tumors or polyps	_____Implant	

Accidents or significant trauma _____
Surgeries _____
_____
Allergies _____
_____
List medications you have taken in the past six months. Include vitamins, herbs, drugs etc.(even if you take them only occasionally)_____
_____
_____

Occupational Stress Factors---Physical, psychological, chemical: _____
_____

Lifestyle---Have you undergone a major life change in the past year, (i.e. change in job, marital status, birth, death, move, etc.)?_____

_____

Describe your general overall emotional status _____

_____

_____

Please indicate if you use any of the following; include frequency and amount.:

Alcohol_____

Cigarettes/Tobacco products_____

Caffeine_____

Cravings_____

Sleep---How many hours of sleep do you require?_____ Are you refreshed upon awakening?_____

Do you experience insomnia_____ Describe the frequency and nature_____

_____

Skin and Hair

_____ Dry hair
_____ Hair loss
_____ Eczema
_____ Hives
_____ Itching
_____ Psoriasis
_____ Rashes
_____Warts
_____Acne
_____Fungal Infections

Head, Eyes, Ears, Nose and Throat

_____Headaches: Where is the discomfort, forehead, back, top, sides or temple? _____

_____

_____ Dizziness
_____ Dry eyes
_____ Red eyes
_____ Night blindness
_____ Cataracts
_____ Glasses/Contacts
_____ Spots or floaters
_____ Earaches
_____ Ringing in ears
_____ Poor hearing
_____ Chronic sinus drainage
_____ Migraine headaches with nausea
_____ Sinus Pain
_____ Frequent sinus infections
_____ Recurrent sore throat
_____ Sensation of something stuck in throat
_____ Dry nose
_____ Nose bleeds
_____ Grinding teeth
_____ Sores on lips, tongue or gums
_____ Facial Pain
_____ Teeth or gum problems
_____ Jaw Pain

Cardiovascular

_____ Irregular heart beat
_____ Palpitations
_____ Fainting
_____ Cold hands or feet
_____ Swelling of hands
_____ Swelling of feet or ankles
_____ Difficulty breathing
_____ Varicose veins
_____Fast pulse (over 100 /minute)
_____Slow pulse (less than 60 /minute)
_____Red or flushed face

Respiratory

_____ Cough
_____ Phlegm
_____ Difficulty breathing when lying down
_____ Shortness of breath with daily activity
_____ Prone to getting respiratory infections

Gastrointestinal

Describe your appetite (poor, good, excessive, irregular)_____

_____ Abdominal distention
_____ Hemorrhoids
____ Ulcer

_____ Bad breath
_____ Belching
_____ Constipation
_____ Diarrhea
_____ Gas
_____ Indigestion/reflux
_____ Nausea
_____ Rectal pain
_____ Taste; sour, bitter, sweet, etc
_____ Vomiting
____ Irritable bowel syndrome
____ No appetite for breakfast

Genitourinary

_____ Blood in urine
_____ Frequent urination
_____ Urgency to urinate
_____ Pain on urination
_____ Decrease in urine flow
_____ Inability to empty bladder
_____ Kidney stones
_____ Sores on genitals

Do you easily get bladder infections?_____

Do you wake up at night to urinate_____ How often?_____

Reproductive / Gynecologic:

_____ PMS
_____ Miscarriages
_____ Hot Flashes
_____ Infertility
_____ Breastfeeding
_____ Are you pregnant or trying to conceive

Male reproductive: _____Vasectomy _____Impotence _____Premature ejaculation _____Infertility

Prostate Gland Problem_____

Musculoskeletal: Pain location.

_____ Neck
_____ Shoulder
_____ Elbow
_____ Wrist
_____ Hands/Fingers
_____ Upper Back
_____ Mid Back
_____ Lower Back
_____ Pelvis
_____ Hips
_____ Knees
_____ Ankles
_____ Feet/Toes

Describe the problem, nature and quality of the pain, disabilities and the limitations you experience due to this/these problems. _____
_____

Aroma Questions:

Are there any particular scents or aromas that bother you? _____

Are there any particular scents or aromas that you especially enjoy? _____

Do you have allergic reactions to any scents? Which? _____

I affirm that I have truthfully answered all questions about my health on this Aromatherapy Intake Form.

Signed: _____