



Aromatherapy Massage Consultation Form

Please take a moment to fill out the questionnaire below. Your answers will allow your therapist to target your specific conditions and provide you with a truly personalised experience.

Name _____

Telephone _____

Date of Birth _____

Mobile _____

Email _____

Work _____

How did you hear about us? _____

Medical History

- Hyper Sensitive Skin
- Allergy (Please specify)
- Glandular Fever / Chronic Fatigue
- Lymphatic Cancer
- Heart Disease
- Circulatory Problems
- Medication
- Blood Pressure Abnormality
- Thrombosis / Blood Clots
- Epilepsy
- Diabetes
- Phlebitis / Varicose Veins
- Neuropathy / Nerve Damage
- Pregnancy

Lifestyle

Tell us how you are feeling and what your needs are by ticking the appropriate boxes and your therapist will choose the most suitable blend for you.

- Worried / Anxious - Light Relax
- Need to Unwind - Light Relax
- Exhausted - Deep Relax
- Trouble Sleeping - Deep Relax
- Out of Balance - Rescue Equilibrium
- Monthly Blues - Rescue Equilibrium
- Mood Swings - Rescue Equilibrium
- Stiffness - De-Stress Muscle
- Muscle Tension - De-Stress Muscle
- Emotionally Drained - De-Stress Mind
- Under Pressure - De-Stress Mind
- Overactive Mind - De-Stress Mind
- Jetlagged - Revive Morning
- Overindulgence - Revive Morning
- Need a Pick Me Up - Revive Evening
- Weary / Jaded - Revive Evening

Previous Operations / Illnesses / Fractures

Declaration

I confirm that the above statements are true and correct and that Essential Therapie cannot accept liability for injury suffered because of incorrect or omitted information.

Signed _____

Date _____

