Lavanda
AROMATHERAPY & BOTANICAL PRODUCTS

Naturopathy Center

Confidential Client Consultation Form

Name _____ Today's Date _____

Phone (Home, Cell, Work) _____

Address & Zip _____

Email _____

Birthdate _____ Occupation _____

How did you hear about Lavanda Aromatherapy Naturopathy Center? _____

_____

The following questions are asked to gain a better understanding of your general health and lifestyle.

Do you have a pacemaker or any metal implants in your body such as pins in bones, copper IUD, metal plates (except dental fillings), etc.? _____

Do you wear hearing aids? _____

Do you smoke? _____ If yes, how many per day? _____

What medications do you take regularly? _____

_____

_____

What vitamins/nutrients/supplements/enzymes, etc. do you take regularly?

_____

_____

_____

How much water do you drink each day? _____

How many solid hours of sleep do you get each night? _____

Do you exercise regularly? _____ What form? _____

How many meals do you eat per day? _____

What time of day do you eat your meals? Breakfast _____ Lunch _____ Dinner _____

Do you eat snacks during the day? _____ If so, when? _____

How many bowel movements do you have per day? _____

Are you currently being treated by a Doctor, Chiropractor or any other Practitioner?
Yes ☐ No ☐

If yes, explain:_____

_____

How many hospitalizations/surgeries have you had? _____ What were they? _____

_____

_____

_____

Describe what bothers you (in your body, mind, emotions or whatever) _____

_____

_____

What are your greatest fears? _____

Is there something in your life that you want to do that you are not currently doing? _____

_____

What is keeping you from doing it? _____

_____

How does that make you feel? _____

_____

What does “health” mean to you? _____

_____

What do you believe will help you to get your body, mind and emotions in balance? _____

_____

_____

_____

_____

Regarding your eating and drinking habits, please check all that apply.

☐ Artificial Sweeteners	☐ Decaffeinated Drinks*	☐ Legumes	☐ Pork	☐ Vegetables
☐ Bacon, Sausage,	☐ Desserts	☐ Liquor*	☐ Processed Meats**	☐ Vegetarian Diet
☐ Beef	☐ Eggs	☐ Margarine	☐ Salads	☐ Water*
☐ Beer*	☐ Fish	☐ Milk-Dairy	☐ Salt	☐ Wheat
☐ Butter	☐ Fowl	☐ Milk Non-Dairy	☐ Seafood	☐ Wild Game**
☐ Carbonated Drinks*	☐ Fruit	☐ Nuts & Seeds	☐ Spicy Foods	☐ Wine*
☐ Coffee*	☐ Herbal Teas*	☐ Oils**	☐ Sugar	☐ Yogurt
☐ Dairy**	☐ Juices*	☐ Olives	☐ Tea*	

Please list any comments or concerns about your eating and drinking habits below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SYMPTOMS AND AREAS OF CONCERN

(Please check all that apply)

☐ Acid Reflux	☐ Circulation	☐ Hair	☐ Menopause	☐ Seizures
☐ Acne	☐ Colitis	☐ Happiness*	☐ Menstrual Cramps	☐ Shingles
☐ ADD/ADHD	☐ Common Cold	☐ Headaches	☐ Migraines	☐ Sinus Issues
☐ Alcoholism	☐ Cold Hands/ Feet	☐ Hearing	☐ Mononucleosis	☐ Skin Issues
☐ Allergies	☐ Colic	☐ Heart	☐ Mood Swings	☐ Snoring
☐ Anemia	☐ Colon	☐ Heartburn	☐ Morning Sickness	☐ Sore Throat
☐ Anger*	☐ Controlling	☐ Hemorrhoids	☐ Motion Sickness	☐ Spinal
☐ Anxiety*	☐ Constipation	☐ Herpes	☐ Mucous	☐ Stomach
☐ Arthritis	☐ Cough	☐ HIV/AIDS	☐ Nails	☐ Stroke
☐ Asthma	☐ COVID	☐ Hives	☐ Nausea	☐ Sty
☐ Athlete's Foot	☐ Dandruff	☐ Hormones	☐ Nervousness*	☐ Surprise*
☐ Avoidance*	☐ Depression*	☐ Hot Flashes	☐ Nose Bleeds	☐ Teeth
☐ Back Pain	☐ Diabetes	☐ Impotence	☐ Numbness	☐ Tennis Elbow
☐ Bad Breath	☐ Diarrhea	☐ Incontinence	☐ Osteoporosis	☐ Thyroid
☐ Bell's Palsy	☐ Disgust*	☐ Indigestion	☐ Overwhelmed	☐ Tonsillitis
☐ Blood	☐ Dizziness	☐ Inflammation	☐ Pain	☐ Tumors
☐ Breathing	☐ Ear Infection	☐ Insomnia	☐ Parasites	☐ Ulcers
☐ Bronchitis	☐ Ear Ringing	☐ Jealousy*	☐ Parkinson's	☐ Urinary
☐ Bruises	☐ Eczema	☐ Joint Pain	☐ Perspiration	☐ Varicose Veins
☐ Cancer	☐ Epilepsy	☐ Kidneys	☐ PMS	☐ Vertigo
☐ Candida	☐ Eyesight	☐ Kidney Stones	☐ PTSD	☐ Warts
☐ Canker Sores	☐ Fatigue	☐ Laryngitis	☐ Pneumonia	☐ Weight-Over
☐ Carpal Tunnel	☐ Fever	☐ Leukemia	☐ Pregnancy	☐ Weight-Under
☐ Cataracts	☐ Flu	☐ Liver	☐ Prostate	☐ Worry*
☐ Cellulite	☐ Fluid	☐ Low Libido	☐ Psoriasis	☐ Yeast Infections
☐ Chest Congestion	☐ Gallstones	☐ Lung Issues	☐ Rashes	☐ Other:
☐ Chest Pain	☐ Gas	☐ Lupus	☐ Sadness*	
☐ Cholesterol	☐ Gout	☐ Lymph Glands	☐ Sciatica	

Cancellation Policy:

We have implemented a cancellation policy to enable us to better utilize the available appointments for our clients.

We are dedicated to assist you on your personal journey for health and wellness. We devote a lot of time, attention, care and resources into our individual wellness consultations, services, and home programs. We make our commitment to reserve time for you and we appreciate you to do the same.

Due to the length of appointments, if you cancel your appointment, you are preventing the ability of others to have the opportunity to take this appointment time.

We ask if you need to cancel or reschedule your appointment that you do so by contacting us by phone, email, or text, by noon (12:00 p.m. Central) two (2) business days prior to your scheduled appointment. If your appointment is cancelled at any time after noon (12:00 p.m. Central) two (2) business days prior to your scheduled appointment, you will be charged 50% of the scheduled service. We do not offer any refunds, returns or exchanges.

Signature: _____Date:_____

Consent and Disclaimer

I understand I am here to learn about better health practices and nutrition, and I may be offered information and/or services, as they relate to or about, Lavanda Aromatherapy and Botanical Products, food supplements, herbs and digestive enzymes as a guide to general good health and overall life balance.

I have willingly come to this session, and any future sessions, seeking information for self-care and self-healing strategies in natural, complementary and alternative means to support my own personal health and wellness goals. I am not on this visit or any subsequent visit as an agent for federal, state, or local agencies or on a mission of entrapment or investigation.

I understand this session, and any future sessions, is not a substitute for a medical examination. I fully understand the Practitioner who counsels me is not a medical doctor, or any other physician, and I am not here for medical diagnostic purposes or medical treatment procedures.

I understand the services performed are at all times restricted to consultation matters intended for the maintenance of the best possible state of natural health. I understand the Practitioner does not diagnose illness, disease or any other physical or mental disorder. Likewise, the Practitioner does not prescribe medical treatments, remedies for disease, pharmaceuticals or perform any spinal adjustments or massage therapy. The Practitioner does not make suggestions about altering medical care I may be under or medications I may be taking. Furthermore, I understand it is recommended I see a medical doctor or other physician for any ailment that I may have.

I understand the Practitioner will provide me with information and tools for prevention and maintenance for my own personal health and wellness goals. If I am provided a Home Program, I agree it is my decision to follow the Home Program and will not hold the Practition er responsible if I do not follow the Home Program. I understand the Home Program is a natural, alternative, and complementary means to assist me in supporting and strengthening my body physically, psychologically, spiritually and mentally in a safe and natural manner.

By signing below, I have read and understand the above information and give my permission to the Practitioner to begin my self-care and self-healing program to support my own personal h ealth and wellness goals and journey.

Signature: _____Date:_____

Thank you for taking time to complete this questionnaire. Your information will be helpful in creating a personalized program designed specifically for you.

All information you provide is kept confidential.