

PATIENT PERSONAL INFORMATION

Our Reference:

Chiltern Aromatherapy

01494-816651

www.chilternaromatherapy.co.uk



IMPORTANT: Please note that your personal information as detailed on this sheet remains confidential. Where you have consented to our contacting your GP, we will do so quoting your full name, address, and date of birth, as this allows your GP to locate the correct patient file. Where you have consented to our sharing or publishing research information about you, we only ever use our Reference Number, which is written above. No other information about you is ever disclosed to a third party. Any information about you which is stored on a computer is filed under the Reference Number, and is non-identifiable. The data provided on this sheet is not entered onto any computer.

About You

| | | | |
|---|---|---|--|
| Full Name: | | Date of Birth: | |
| Your Email: (please use capitals) | | Home / Phone: | |
| Email Consent: | May we use your email address to send you treatment follow ups, and occasional newsletters? (YES / NO) | Mobile Phone: | |
| Your Address: (please include postcode) | | Work Phone: | |
| | | Your Occupation: | |
| | | Marital Status / Partner's Occupation: | |
| GP Name & Surgery: | | GP Phone: | |

Your Declaration: The information that I have given is true and correct. I understand that any aromatherapy treatment will be based on my answers, and I accept responsibility accordingly for incorrect information. I consent to examination and treatment. You may / may not (*please delete*) contact my GP for information and advice where appropriate. You may / may not (*please delete*) share details of my treatment and outcome with other health professionals both directly, or indirectly by publication, and I note that at all times my personal information will remain private and confidential and will not be divulged to any third party whatsoever

| | | | |
|----------------|--|----------------------|--|
| Signed: | | Today's Date: | |
|----------------|--|----------------------|--|

PATIENT HEALTH INFORMATION

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About Your Health

- Is there any family history of serious illness, with you, your brothers and sisters, or your parents? No Yes
- Do you have sensitive skin? No Yes
- Do you have any skin problems such as eczema, or is your skin unusually dry, or greasy? No Yes
- Are you allergic to anything, such as nuts? No Yes
- Are you right-handed or left-handed? Right Left
- Do you regularly suffer from any aches and pains? No Yes
- Have you ever dislocated a joint, or had any joint problems, or any arthritis? No Yes
- Have you ever had any operations? No Yes
- Do you have any scar tissue? No Yes
- Have you had any plates or pins inserted? No Yes
- Do you have poor circulation? Do your hands and feet regularly get cold? No Yes
- Do you have any broken veins, varicose veins, or thrombosis? No Yes
- Do you know of any heart problems? Do you have a pacemaker fitted? No Yes
- Do you have either a high or low blood pressure? No Yes
- Do you smoke? If so, how many per day? No Yes
- Do you ever feel short of breath? No Yes
- Do you know of any respiratory problems? No Yes
- Do you drink alcohol? If so, how many units a week? No Yes
- Do you ever take recreational drugs? No Yes
- Do you know of any kidney or liver problems? No Yes
- Do you regularly suffer from either constipation, or from diarrhoea, or have an irritable bowel? No Yes
- Do you have any dietary problems? No Yes

(if yes, give additional information below)

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(if yes, give additional information below)

- Do you feel that you are overweight ? No Yes
- Have you ever had an epileptic attack ? No Yes
- Have you ever had hepatitis ? No Yes
- Do you have problems sleeping ? No Yes
- Do you ever feel depressed or deeply unhappy ? No Yes
- Do you take any regular medication ? No Yes
- Do you experience a lot of stress ? No Yes
- Are you being treated by your GP currently ? No Yes
- Do you feel at all unwell today ? No Yes
- Is there anything else which we haven't asked you, and which might be relevant to an aromatherapy treatment ? No Yes

For Ladies Only

- Are you pregnant ? Could you be ? No Yes
- Do you take any oral contraceptive, or do you have a contraceptive device fitted ? No Yes
- Do you have any children ? Normal deliveries?
Any postpartum urinary incontinence? No Yes
- Do you regularly suffer from cystitis or thrush ? No Yes
- Do you often experience PMS ? No Yes
- Do you have irregular or very uncomfortable periods ? No Yes
- Do you experience any vulval irritation, pain or discomfort at any time? No Yes
- Do you experience any pain or discomfort during intercourse? No Yes