Awakening with Diane
REIKI - LIFE COACH - ESSENTIAL OILS

awakening.dianeandra@gmail.com
awakeningwithdiane.com
208-870-2395

Aromatouch Intake Form

Name: _____

Date of Birth: _____

Date of Initial Visit: _____

Email Address: _____

Address: _____

City / State / Zip: _____/____/_____

Emergency Contact Name: _____

Emergency Contact Phone: ( ) _____

Relationship: _____

The following information will be used to help plan safe and effective Aromatouch sessions. Please answer the questions to the best of your knowledge.

Have you ever had an Aromatouch session? ◯ Yes ◯ No

If yes, how often do you receive Aromatouch? _____

If yes, please describe the outcome you hoped for from your previous Aromatouch session(s), and what your actual experience was:

Do you have any difficulty lying on your front or back? ◯ Yes ◯ No

If yes, please explain:

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Do you have any allergies or sensitivities to any plants or essential oils? ◯ Yes ◯ No

If yes, please explain:

Are you currently under medical supervision? ◯ Yes ◯ No

If yes, please explain:

If you are under the care of a physician for any health concerns, please list those concerns here:

Is there anything else about your health that you think would be useful for your Aromatouch practitioner to know to plan a safe and effective Aromatouch session for you?

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Aromatouch Consent Form

I, _____ (print name) understand that the Aromatouch I receive is provided for the basic purpose of relaxation and relief of tension and stress. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that adjustments can be made for my level of comfort. I further understand that Aromatouch should not be construed as a substitute for medical examination, diagnosis, or treatment, that I should see a physician or other qualified medical specialist for any physical or mental illness, and that nothing said during the session should be construed as such. I affirm that I stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that here shall be no liability on the practitioner's part should I fail to do so.

Signature of Client: _____ Date: _____

Signature of Practitioner: _____ Date: _____

Signature of Parent: _____ Date: _____
(if client is under the age of 18)