IVY COUNSELING GROUP, LLC
NURTURING INTERNAL RESILIENCE & STRENGTH

PLEASE READ CAREFULLY

I understand that the aromatherapy sessions I receive are customized to my personal concerns and complaints. If I experience any discomfort during a session, I will immediately inform my practitioner. I further understand that aromatherapists do not diagnose, treat, or prescribe for medical conditions. The aromatherapy work in no way precludes treatment from my physician, therapist, hospital, chiropractor and/or any other medical treatments or medications currently prescribed. Aromatherapy sessions are designed to be complementary to traditional medicine.

Signature: _____ Date: _____

Complaints/Concerns

What is your primary concern at this time? _____

Please list the time of onset. _____

What makes you feel worse? _____

What makes you feel better? _____

Medical Information

Are you pregnant? Yes / No	Are you currently trying? Yes / No	Are you breastfeeding? Yes / No

Chronic Conditions (please check if relevant)

___ High Blood Pressure (Hypertension)
___ Low Blood Pressure (Hypotension)
___ Epilepsy
___ Any seizure disorder other than epilepsy

Please list any and all allergies that you may have in the space provided.

Are you under the care of a physician? If so, please list the condition(s) that you are being treated for.

Please list any current medications that you may be taking.

Medical Information Continued

Please list any supplements that you may be taking.

Please list surgeries in the space provided.

Are there any specific restrictions that your physician has put you under in regards to the above?

General Wellness Profile

How many times per day do you use the following?

Coffee, Tea, and/or Soft Drinks _____ Alcohol _____

Cigarettes, Cigars, and/or Tobacco _____ Other Drugs _____

Please describe your current exercise regimen, including hours per week, activities, or if you are not currently participating in an exercise regimen.

How many hours of sleep do you normally get per night? _____

Is your sleep restful (circle one) Yes No Occasionally

Describe your sleep in greater detail.

Are there any particular aromas that disturb you?

Are there particular aromas that you enjoy?

Describe your diet. Do you feel it is wholesome and nutritious?

Emotional and Energetic Concerns

If any of these concerns apply on a scale of 1 to 5 (5 being the most severe), and add the total number. If you are experiencing any concerns that may not be listed, please feel free to add it to the list and rate accordingly.

Uncertainty _____	Addictive nature (either physical or mental) _____
Control Issues _____	Dealing with old emotional wounds or trauma _____
Lack of Clarity _____	Issues with anger _____
Fear _____	Tend to be negative _____
Stuck in my emotional growth _____	Feeling lonely _____
Wanting deeper connection to the divine _____	I am mentally, emotionally exhausted _____
Anxiety _____	I lack confidence _____
Lack of Joy _____	I hold grudges _____
Blocked Energy _____	I feel repressed _____
Wanting change but unable to move forward _____	I am out of balance _____
My mind thinks too much _____	I am not flexible _____
Allow everything to bother me _____	I have lost my creativity _____
Lack of willpower _____	Total: _____

Do you frequently suffer from stress? Yes / No

Please rate your level of stress in the following areas from a scale of 1= mild to 10= overwhelming.

Stress with work or school: _____

Stress with primary of intimate relationships: _____

What is your favorite color?

What is your favorite vacation destination? Why?

Please provide any other information or concerns that you think we should know in order to treat you safely and effectively.