Client History Form

NAME: _____ **AGE:**_____ **DATE OF BIRTH:**_____

ADDRESS: _____ **REFERRED BY:**_____

EMAIL: _____ **OCCUPATION:** _____

PHONE:_____(mob)_____(hm)_____(wk)

PRACTITIONER'S NAME:_____ **DATE OF SESSION:**_____

IMPORTANT SAFETY Q's

☐ I have a current blood clot (eg. ischemic stroke, embolism, thrombosis, DVT)
Raindrop/VF Technique must not be performed.

☐ I am on pharmaceutical or herbal medication for thinning the blood

☐ I have high blood pressure (HBP), *or*

☐ I am on medication to control HBP

☐ I am/may be pregnant (less than 15 wks)

☐ I am 15 or more weeks pregnant

☐ I have had an epileptic seizure

☐ I am under 5 years of age

☐ I am under 18 months of age
Refer Safety Data Pages for avoid & caution oils. HBP or Medication for: Omit Lymphatic Foot Pump & Finger Pull. Pregnant: Pregnancy Release Form; Refer Age/Other in Modification Table; If 18+wks, place pillow under right hip & shoulder when on back.

☐ I am breastfeeding
Certain essential oils may increase or decrease milk production, and may be tasted in the milk. Refer Modification Table (top left + Age/Other).

☐ I am allergic to nut, seed or vegetable oils. The oils I am **SAFE to use topically** are:

Olive	☐	Coconut	☐
Sesame	☐	*Young Living* V6 oil	☐
Almond	☐	Safflower/Sunflower	☐

Refer to CDR. Only blends with no carrier oil or containing one of your safe carrier oils will be used.

☐ I've had a past reaction to chemicals, pharmaceuticals, herbs or essential oils (and have not safely used this same oil in *Young Living* brand since the reaction).

Details:.....

.....
If reaction was severe, do Level 2 or 3 Modification for Toxicity. If reaction was to essential oils, also avoid those essential oils and blends containing (refer CDR).

OPERATIONS/MEDICATION

List by year *all* operations/procedures involving general anaesthetic:

.....

.....

.....

.....

List current pharmaceutical medications

.....

.....

.....
Request regular monitoring from your doctor, and adjustment to medication levels if required.

SPECIFIC CONDITIONS

☐ In the past 12 months I've had Bone Cancer *or* a Spinal Fracture *or* Spinal Operation *or* Severe Osteoporosis

Details:.....*OR*

☐ I have a Herniated/Slipped/Bulged Disc or a Spinal Injury *AND* I am experiencing one or more of these symptoms: Pain that wakes me at night; Pain which cannot be relieved; Numbness, tingling, weakness or pins and needles down my arms or legs; A change in bladder or bowel function corresponding to the onset of the disc issue
(Unless Medical Clearance): Omit VF Thumb Rolls, Finger Straddle, Finger Pull, Lymphatic Foot Pump, Neck Stretch; All other back moves performed gently.

☐ I have current back, neck or sciatic pain

☐ I have a current/past back or neck injury

☐ I have a Herniated/Slipped/Bulged disc

☐ I have Scoliosis and/or Rods in my spine

Details:.....

.....
Exercise caution when working around this area, checking to ensure no discomfort. Scoliosis: work up or down spine according to which gives best results.

☐ I have Multiple Sclerosis

☐ I am a Quadriplegic/Paraplegic

☐ Back pain or nerve issue affects my mobility

Details:.....
Raindrop Technique will be performed down the spine

☐ I have Arteriosclerosis/Atherosclerosis

☐ I have Cancer *or* Acute Inflammation from bacteria/viruses/poisons/allergens

☐ I have current or past Heart Disease (including Cardiomyopathy, Congestive Heart Failure or Heart Attack). Details:

.....
Omit Finger Pull and Lymphatic Foot Pump.

☐ I have a skin rash/lesions/stitches *OR* I have

☐ Synthetic or metal parts in my body (pins, pacemaker, breast/metal/other implants, contraceptive implants/IUDs, internal mesh)

Details:.....
Essential oils will not be applied directly over top

MENTAL/EMOTIONAL STATE

☐ I am highly: Stressed, Emotional *or* Anxious

☐ I have depression or take antidepressants

☐ I have a diagnosed mental health condition:

Details:.....
If any of the above 3 boxes are ticked, a Level 1 or 2 Modification for Emotions will be chosen for 1st session

CHEMICAL EXPOSURE

☐ I am a "Universal Reactor" with extreme environmental &/or chemical sensitivities
A Level 3 Modification for Toxicity will be chosen.

☐ I've had significant chemical exposure from my environment, amalgam fillings, hobbies, profession &/or recreational drug use.

Details: .....

☐ I am a smoker. I average.....cigarettes/day

☐ I drink more than 4 glasses of alcohol per week. If so, how many?.....

☐ I drink fewer than 8 glasses/2 ltrs of plain water a day. How many glasses a day?.....

☐ I don't have bowel movements every day. If so, how many times per week?.....

IN THE PAST 12 MONTHS:

☐	**Autoimmune disease**	☐	**Arthritis**
☐	**High Blood Pressure**	☐	**Diabetes**
☐	**Parkinsons/M.S.**	☐	**Stroke**
☐	**Dementia/Alzheimers**	☐	**Cancer**
☐	**Heart Disease**	☐	**HIV/AIDS**
☐	**Chemo/Radiation**	☐	**Hepatitis**
☐	**Chronic Fatigue**	☐	**Emphysema**
☐	**Lyme Disease**	☐	**Asthma**
☐	**Fibromyalgia**	☐	Cystitis
☐	Glandular Fever	☐	Migraines
☐	Ross River Fever	☐	Candida/Thrush
☐	Allergies	☐	Herpes/Cold Sores

☐ Dermatitis/Eczema/Psoriasis/Rosacea/Acne

☐ IBS/Colitis/Diverticulitis/Leaky gut

☐ Had amalgams removed from my teeth

☐ Had a general or local anaesthetic

☐ Been on antibiotics *or* been vaccinated

☐ Taken synthetic hormones -IVF, IUI, HRT, thyroxine, contraceptive pill

☐ Been on pharmaceutical meds (other than antibiotics, vaccinations or hormones)

Other illnesses/infections in past 12 mths
Bold if severe or if underlying health compromised

☐ .....

☐ .....

☐ .....

HEALTH REGIME

In the past 3 months I have:

☐ Been on a 10+ day liquid-only detox regime

☐ Consumed YL oils or supplements daily

☐ Received a full Raindrop Technique