Client History Form

NAME: _____ AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____ REFERRED BY: _____

EMAIL: _____ OCCUPATION: _____

PHONE: _____ (Mob) _____ (Hm) _____(Wk)

PRACTITIONER'S NAME: Annmarie Kiernan DATE OF SESSION: _____

IMPORTANT SAFETY Q'S

☐ I have a current blood clot (e.g. Ischemic stroke, embolism, thrombosis, DVT)
Raindrop/VF Technique/Hot Stone must NOT be performed until written medical clearance given

☐ I have a bleeding disorder
Hot Stone must NOT be performed until written medical clearance given record in specific conditions

☐ 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
Ref Safety Data for avoid & caution oils.
HBP or Medication for: Omit Finger Pull.

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

☐ I am 15 or more weeks pregnant
1. ***Hot Stone must NOT be performed.***
2. ***Ref Safety Data for avoid & caution oils***
3. ***Pregnant: Pregnancy Release Form;***
4. ***Refer Age/Other in Modification Table; If 18+wks:***
5. ***Place pillow under right hip & shoulder when on back***

☐ I have had an epileptic seizure

☐ I am under 5 years of age

☐ I am under 18 months of age
Ref Safety Data for avoid & caution oils & Age Other

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

☐ I have a nut, seed or vegetable oil allergy.
OILS I AM SAFE to use topically:

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

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

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

Details: .....

.....

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

OPERATIONS/MEDICATION

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

Details: .....

.....

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* 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 (may be performed in aura),Omit Hot Stones; all other back moves performed gently.

☐ I have current back, neck or sciatic pain

☐ I have a current/past physical 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, check 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 to 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 No Hot Stone Massage

☐ I have a skin rash/lesions/stitch *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 other than depression/anxiety

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
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 litres of plain water a day. How many glasses a day?.....

☐ I don't have bowel movements every day. How many times per week?.....

IN THE PAST 12 MONTHS:

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

☐ 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
Count 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 Nil Raindrop Technique

Submit