Jodi Baglien well being + wisdom studio

Today's Date_____ **Name** _____

Address _____ **City**_____ **Zip**_____

Phone: _____ **Email:** _____ **Add to emailing list? Yes No**

Preferred Method of Contact: Phone? Email? Text? _____ _____

Current Condition

Briefly tell me, what would you like help with today?

_____

_____

On a scale of 1 -3 to what extent does the problem(s) interfere with your daily activities?

_____

Have you ever been given a diagnosis for this problem(s)? If so, what diagnosis and by whom?

_____

What has been prescribed, or suggested? What has helped?

_____

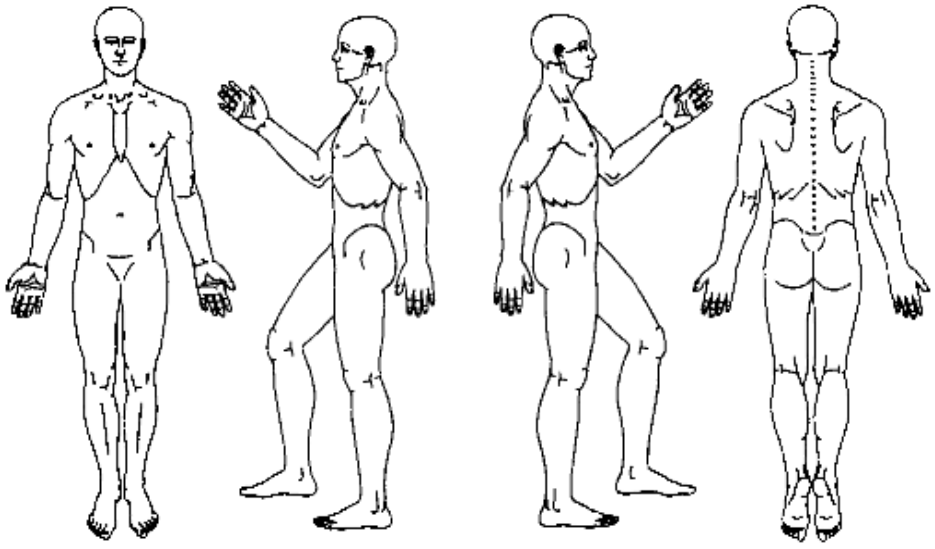
_____

List any recent injuries, surgery, trauma, or disease.

_____

_____

As closely as possible – please draw on the bodies exactly where you are experiencing the pain, stress, issues. If more than one issue, use another color.



Place an X over any areas that are recently injured recent surgery, deep bruising, varicose veins, or ticklish.

Please mark as follows: X - Sometimes experience
XX Frequently experience (daily- weekly)

ST/SP

__ Tired, for no apparent reason
__ Digestive issues __ stomach __ bowel
__ Loose stools or constipation
__ Chronic sinus issues, infection, nasal drip
__ Weakness in muscles, limbs
__ Mental fatigue – foggy/heavy head
__ Hold extra weight easily
__ Crave sweets
__ Bleeding gums
__ Bruise easily
__ Cold Limbs
__ Over think/over worry
__ Indecisive
__ Overly involved in taking care of others
__ Sensitive to criticism
__ Often disappointed

LV/GB

__ Pain in joint/connective tissue
__ PMS –
__ Hemorrhoids __varicose veins
__ Anemia
__ Headaches
__ Neck and shoulder tension
__ Tics or tremors
__ Bitter or metal taste in mouth
__ Sighing (do you notice yourself sighing)?
__ Eyes __ blurred __ floaters __ dry__ red?
__ Dry skin/hair __ brittle nails
__ Depression – prone to?
__ Anger, frustration, irritable
__ When stressed - blow or burst in anger
__ Lack motivation

HT/SI

__ Insomnia, difficulty sleeping
__ Heart palpations / heart issues history
__ Dizziness
__ Cold limbs – poor circulation
__ High or low blood pressure
__ Dream disturbed sleep
__ Feel heat in the face, head, flushed
__ Pale face
__ Anxious, agitation, restless, jumpy
__ Overly emotional /sensitive
__ Poor memory, forgetful, scattered
__ Compulsive behaviors
__ Disconnected, socially uncomfortable
__ Uncontrollable, inappropriate laughter or crying

KI/UB

__ Low back issues - weak, pain, chronic
__ Knees – sore or weak, chronic issues
__ Cold limbs
__ Urinary problems –current or history of
__ Tinnitus – ringing in ear
__ Dark circles under eyes
__ Night sweats
__ Edema
__ 5 pm fatigue
__ Aversion or sensitive to cold
__ Weak bones, teeth
__ Low Libido/ Sexual dysfunction
__ Overly fearful, dislikes change
__ Strong fear of failure
__ Feel insecure, tend to withdraw, or timid
__ No fear - reckless behaviors

LU/LI

__ Prone to respiratory issues
__ Asthma
__ Experience shortness of breath easily
__ Sensitive skin, dry, eczema/psoriasis
__ Rashes _____ Hives
__ Halitosis – bad breath
__ Perfectionist type
__ Deep feelings of sorrow, sadness, grief
__ Withdrawn, distant
__ Feel powerless
__ Rigid thinking

Aromatherapy -

__ Any known allergies to plants?
__ Do you consider your skin highly sensitive
__ Are you receiving treatment for cancer?
__ Are you pregnant or nursing?
__ Do you have a favorite oil/aroma?
_____

Do you have a oil/aroma you don't want used? _____