

THE BAREFOOT DRAGONFLY

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Amy Kreydin
Certified Clinical Aromatherapy Practitioner
Board Certified Reflexologist
Metamorphic Technique Practitioner

Dear Prospective Client:

Thank you for considering The Barefoot Dragonfly for your Holistic Aromatherapy needs. In preparation for your consultation, I am enclosing an Intake Packet for you to review and complete prior to your initial appointment. The Consultation Intake Packet includes:

- Cover letter (1 pages)
- Health History Intake Form (5 pages)
- Informed Consent (1 pages)

Please read the attached information, complete all forms, and bring them with you to your appointment. If your appointment is being held via phone or Skype please email the completed forms 24 hours prior to your appointment to: amy@thebarefootdragonfly.com.

Aromatherapy is a holistic healing science that utilizes concentrated plant extracts in the form of essential oils and hydrosols (aromatic waters), to bring harmony and balance to the body, mind, and spirit. Grounded in a rich history of holistic healing, Aromatherapy supports your own self-healing abilities. Aromatherapy does not seek to pacify symptoms but to remove obstacles to health. Some results can be seen quickly, while more chronic imbalances are resolved gradually, over a period of six months to a year.

It is my honor to serve as your Aromatherapist on this journey of wellness. My mission is to co-create a wellness treatment plan that is customized to your unique needs and goals that supports your health and well-being. I will serve as your teacher and guide as you explore how Aromatherapy can fit into the big picture of your emotional, spiritual, and physical wellness. I look forward to assisting you on this healing journey, our joint effort, utilizing my expertise and insight, along with your intuition and commitment.

"This is the miracle of life: that each person who heeds himself knows what no scientist can ever know: who he is." - Søren Kierkegaard

In Health,

Amy Kreydin, CCAP, NBCRT, BD
Certified Clinical Aromatherapy Practitioner
Board Certified Reflexologist
DONA Trained Birth Doula
Metamorphic Technique Practitioner

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Confidential Health History Form Holistic Aromatherapy Consultation

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care. It should take 15-20 minutes.

Name: _____ Date of birth: _____ Age: _____

Single Married Life Partner Divorced Widowed

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Would you like to receive our monthly and seasonal newsletter via email? Yes No

Subscribers may unsubscribe at any time. The Barefoot Dragonfly is a CAN-SPAM Compliant company.

Care Coordination: _____

Emergency Contact: _____ Phone: _____

Primary Physician: _____ Phone/Email: _____

Specialist Physician: _____ Phone/Email: _____

Who may we thank for referring you?

INITIAL QUESTIONNAIRE

Why are you interested in an Aromatherapy Consultation?

What do you want to achieve or change in terms of your health and wellness?

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HEALTH HISTORY

Are you currently being treated for a medical condition? (Please describe)

Date of last physical exam:

List any physician- or self-prescribed medications (prescription and over-the-counter), vitamins, and/or supplements you are currently taking:

Name	Dosage/Frequency	How long	Reason
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Hospitalizations/Surgeries/Operations (list dates):

Do you have any other past medical history or problems (i.e. illness, trauma, emotional stress, addictions, drug abuse) or anything else that will help us clearly understand your health condition?

DAILY ROUTINE

What time do you rise in the morning?

What time do you go to bed?

How do you generally feel when you wake up in the morning?

Refreshed and rested A little tired Moderately tired Very tired

Describe your current sleep routine (sound, not enough, difficulty falling or staying asleep, not enough, difficulty waking up, too heavy/long, frequent nightmares):

Describe your bowel movements:

Once every 2-3 days Once daily 2-3 times a day Need laxative daily

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How much water do you intake per day: _____

Occupation: _____

Is the majority of your day spent: Sitting Standing Walking

Do you Use: Now Past For how long? Type Frequency

Tobacco _____

Alcohol _____

Caffeine _____

Soft Drinks _____

Recreational Drugs _____

Do you Exercise? Yes No Number of times/ week: _____, Type: _____

Do you experience allergic reactions to any substances (food, environmental, etc)? Yes No
If yes, please explain: _____

Women Only:

Are you trying to conceive? Yes No Are you pregnant now? Yes No

Form of birth control: _____

Your menstrual cycle begins with the first day of bleeding, where are you in your menstrual cycle today? _____

Does your period cause you pain or cramping? Yes No

When? Before During After Period

Pregnancies (please include losses and terminations):

Year	Vaginal or C section	Complications or conditions of note
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_____	_____	_____
_____	_____	_____
_____	_____	_____

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CONSTITUTIONAL ASSESSMENT TOOLS

Natural medicine - also called holistic medicine, and complementary medicine - is our modern take on traditional healing systems. Ayurvedic medicine, traditional Chinese medicine, and Ancient Greek medicine, all share a common set of beliefs:

- That the body has an innate ability to self-heal;
- That nature has healing powers;
- And that body, mind, and spirit do not heal separately from each other.

In observing these ancient systems of medicine we seen an emphasis on observing patterns within ourselves and honoring the cycles of nature for individual wellness as well as healing within the community. The following assessment tools act as a guide for self-examination and self-development observations - these insights do not place judgment or restrictions on wellness but help offer insight into one's own place in the cosmos.

Constitutional Body Systems Review

Please mark all of the conditions below that you have now (**X**) or had in the past (**P**)

WOOD (Liv/GB)

- Headaches
- Migraines
- Ringing in Ears
- Visual Problems
- Red/Dry/Itchy Eyes
- Eczema
- Rectal Pain/hemorrhoids
- Gallstones
- Tense Shoulders
- Tense Neck
- Insomnia (11pm-3am)

FIRE (Ht/SI)

- Dry Scalp
- Rashes/Skin Eruptions
- Cysts
- Ear Infections
- Sore Throat
- Lymphatic Swelling
- Hot Hands/Feet
- Heart Palpitations
- Aversion to Heat
- Gum Problems
- Nosebleeds
- Itchy/Burning Skin
- Thirst
- Vivid Dreams
- Night Sweats
- Facial Redness

EARTH (Sp/ST)

- Indigestion
- Flatulence
- Belching
- Food Allergies
- Tummy Ache/Ulcer
- Diarrhea
- Anemia

- Bad Breath
- Mouth Sores
- Heartburn
- Prolapsed Organ
- Strong Appetite
- Nausea
- Abdominal Bloating

METAL (Lu/LI)

- Bronchitis
- Asthma
- Shallow Breathing
- Cough
- Sinus Congestion
- Nasal Infections
- Hay Fever/Allergies
- Respiratory Problems

WATER (Ki/UB)

- Hearing Loss
- Dizziness
- Lower Back/Neck Pain
- Sinus Congestion
- Edema
- Dark under the Eyes
- Aversion to Cold
- Thinning Hair/Hair Loss
- Frequent Urination
- Kidney Stones
- Weak Legs/Knees
- Asthmatic Cough
- Rapid Weight Change
- Loose Teeth
- Reduced Sex Drive
- Thyroid Problems
- Diabetes
- Perspire Easily

CARDIOVASCULAR

- High or low blood pressure
- Blood clots
- Varicose veins
- Cold Hands/Feet
- Swelling of Hands/Feet
- Other _____

RESPIRATORY

- COPD
- Pneumonia
- Chest Congestion
- Frequently catching colds
- Other _____

FEMALE REPRODUCTIVE

- Frequent urinary tract infections
- Ovarian Cyst
- Uterine Fibroid
- Menopause symptoms
- Breast lumps
- Infertility
- Low libido
- Other _____

NEUROLOGICAL

- Seizures
- Numbness/tingling in limbs
- Paralysis
- Concussion
- Other: _____

IMMUNE/LYMPHATIC

- Chronic Fatigue Syndrome
- Rheumatoid Arthritis
- Lupus
- Aids/HIV
- Cancer
- Other: _____

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AYURVEDIC PROFILE

Please circle the descriptions that best describe you at this time in your life.

	Vata	Pitta	Kapha
My endurance is...	Fair	Good	High
My appetite is...	Variable, scanty	Strong	Low, Steady
If I miss a meal, I am...	Anxious or lightheaded	Irritable	Not significant
Digestion after eating is...	Prone to gas and/or bloating	Heartburn	Heavy, sluggish
I have bowel movements...	Less than once a day	2 or more times a day	Once a day
My bowel movements are...	Irregular, dry, hard, tendency towards gas and constipation	Regular, soft, sometimes loose	Regular, solid, well formed, sometimes sluggish
My thirst is...	Variable	Excessive	Sparse
I enjoy physical activity that is...	Fast and very active	Medium	Slow and steady
My sleep has been...	Light, often awaken and struggle to fall back asleep	Moderate, 6-8 hrs, if any difficulty it is in falling asleep	No problem sleeping, I get more than 8 hrs
When I am speaking I am...	Talkative, may ramble	Speak purposefully	Speak less cautiously
My mind is...	Restless, always active	Aggressive, intelligent	Calm
My memory is...	Short-term is best	Good general memory	Long-term is good
I'm known for my...	Adaptability	Courage	Love
Emotionally I feel...	Exhausted, restless, anxious, nervous	Tense, tired, determined, tendency toward anger	Lethargic, low energy, I don't want new projects
My interests & habits include...	Dancing, artistic activities, talking	Competitive ventures, debate, politics, hunting	Family and social gatherings, cooking, collecting
When I'm stressed I feel...	Tearful and anxious	Angry, aggressive, confrontational	Like I want to hide away
	Vata: _____	Pitta: _____	Kapha: _____

AROMATHERAPY

I enjoy aromas that are (circle all that apply):

Pungent Lemony Sweet Green Woody Rooty

My favorite essential oil(s) are:

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Informed Consent to Treatment

Aromatherapy is a holistic science-art that utilizes concentrated plant extracts in the form of essential oils and hydrosols (aromatic waters), to bring harmony and balance to the body, mind, and spirit.

I understand that this consultation is designed to gather information so that my Aromatherapist is able to create a customized treatment plan for my unique goals and needs.

I understand that my Aromatherapist, Amy Kreydin, is not a doctor and does not diagnose or treat for a specific illness nor does she prescribe or adjust medication.

I understand that Aromatherapy is not a substitute for medical treatment, but does complement most types of therapy.

I understand that I am financially responsible for this consultation at the time of my appointment and that if I fail to arrive at the appointed time or miss an appointment I am still responsible for the full amount of the service.

I affirm that I have completed this intake form accurately and honestly, and agree to notify my Amy Kreydin of any changes that may affect my health profile. I understand that all my information is strictly confidential and if I wish my Aromatherapist to discuss my case with another practitioner that I may request so in writing.

By signing this form, I give my consent to an Aromatherapy Consultation and Customized Treatment Plan. I acknowledge that I have read and understand the information below:

- If I have been diagnosed by a licensed health professional as having any disease, injury, or other physical or mental condition, I understand that I should inform the person who made the diagnosis, about the services I will be receiving, and whether or not I intend to discontinue any treatment or therapy which had been previously ordered, prescribed, or recommended by a licensed health professional.
- I understand that by discontinuing any such treatment or therapy I agree to hold Amy Kreydin free from any liability, assuming my personal responsibility for any negative outcome resulting from discontinuing that treatment or therapy.

Client Signature _____ Date: _____

Aromatherapists Signature _____

AROMATHERAPY IS NOT A SUBSTITUTE FOR MEDICAL CARE. IF YOU ARE EXPERIENCING ANY SPECIFIC MEDICAL PROBLEM AND HAVE NOT SEEN YOUR MEDICAL DOCTOR, I RECOMMEND YOU DO SO TODAY.