



# JENNSCENTS® INSTITUTE STUDENT FORM

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Please take a moment to carefully read the following client disclaimer and declaration, and sign where indicated.

**Disclaimer:**

I understand the purpose of this consultation is for educational purposes only and is not intended to treat, diagnose, cure, prescribe or replace appropriate medical guidance. I have willingly requested this consultation with \_\_\_\_\_, a Holistic Phyto-Aromatherapist.

**Client Declaration:**

- I am committed to learning a natural health path to enhance my quality of life that includes herbal supplements, aromatherapy and other natural health disciplines.
- I desire to incorporate healthy habits into my lifestyle and way of living to create a better health environment.
- I understand that it is my personal decision to follow a supplemental program or not to follow it.
- I thoroughly understand that this analysis does not replace any additional professional counseling with any medical health care professional and is not intended to be in any way a diagnosis or conflict with any other recommendation or treatments by other practitioners who are licensed by state and federal laws, and also the decision to follow or reject this program is left to my own discretion.
- In addition, I fully and completely understand that you do not treat nor do you make recommendations for the treatment of disease in any form or in any manner whatsoever, and I wish to assure you that I am in no way asking for such treatment.

CLIENT SIGNATURE: \_\_\_\_\_  
*(e-signatures must be in the format of /name/ using a font other than Arial and Times New Roman)*

DATE \_\_\_\_\_

CONSENT TO TREATMENT OF A MINOR By my signature below, I hereby authorize \_\_\_\_\_ to conduct a health analysis service to my child or dependent as necessary.

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_

Name:

Address:

Phone:

Email:

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**HEALTH CONCERNS, ALLERGIES, SURGERIES**

List 1-12 major health concerns, including allergies, surgeries and other important medical info

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	

**HEALTH GOALS – PHYSICAL, MENTAL & EMOTIONAL**

List your top 3 health goals

1	
2	
3	

## DIGESTIVE

<b>"X"</b>	<b>Physical</b>	<b>"X"</b>	<b>Emotional</b>
	Hungry all of the time		Not able to "digest" a situation
	Gas		Self-esteem, self-worth
	Bloating		Confusion
	Hard time gaining weight		Feel like you are losing control
	Poor appetite		Loss of interest, negativity
	Carving carbs and fats		Feeling undernourished or taken care of
	Heartburn or acid indigestion		Can't believe someone has "burned" you
	Food sits heavy in stomach after eating		Overwhelmed and overburdened

## INTESTINAL

<b>"X"</b>	<b>Physical</b>	<b>"X"</b>	<b>Emotional</b>
	Diarrhea		Worry
	Constipation		Not letting a feeling or situation go
	Allergies, hayfever		Irritated by circumstances, feel attacked
	Ulcers		Self-doubt, not feel good enough
	IBS, Colitis, Crohn's		Bombarded and overwhelmed
	Itchy nose, ears		Feel like you are being invaded
	Nightmares		Feel like you are being attacked
	Hard time losing weight		Depression and withdrawn
	Muddled thinking, confusion		Distracted easily
	Body odor, bad breath		Negative thoughts; negativity in general

## HEPATIC (LIVER & GALL BLADDER)

<b>"X"</b>	<b>Physical</b>	<b>"X"</b>	<b>Emotional</b>
	Liver congestion		Anger, aggressive, assertive
	High Cholesterol		Over-protecting and controlling
	Low Cholesterol		Feel overpowered and defeated
	Headaches – tension, migraines		Harboring a heated situation
	Hemorrhoids		Fear about meeting personal demand or goal

## RESPIRATORY

"X"	Physical	"X"	Emotional
	Asthma, shortness of breath, wheezing		Outburst of or uncontrollable grief
	Sinus congestion		Feeling stuck or suffocated
	Bronchitis, pneumonia		Silent grief
	Dry cough		Hurt, hopeless, despair
	Wet cough or excess mucus production		Guilt

## URINARY

"X"	Physical	"X"	Emotional
	Frequent urination (day and/or night)		Annoyed about a circumstance or situation
	Skin irritations, blemishes, dry skin		Suppressed hostility, feel threatened
	Excess oily skin		Blame others
	Excessive perspiration		Feel superior
	Limited or no perspiration		Feel inferior
	Scant or little urine with urge to go		Feeling worthless
	Excessive urine when voiding		Bottling up or holding emotions in
	Burning urination, frequent urinary tract infections		Fear; Phobias
	Incontinence and bladder leakage, bedwetting		Lack of trust of self and others
	Leg cramps, spasms		Fear of the future
	Lower back pain, backache		Feel beaten down
	Dizziness or light-headedness		Nt feel centered, grounded or peaceful
	Puffiness under the eyes		Willingness to do something, lack of will-power
	Gout		Need to dominate, intolerant to others

## LYMPHATIC

"X"	Physical	"X"	Emotional
	Swollen lymph glands		Feel stopped in your tracks, emotional paralysis
	Edema, water retention		Holding onto a negative emotion
	Acne		Not accept self or allow self to receive

## CIRCULATION

<b>"X"</b>	<b>Physical</b>	<b>"X"</b>	<b>Emotional</b>
	Poor circulation		Feel stuck in life, nowhere to go
	Varicose and/or spider veins		Discouraged and disheartened
	Wounds heal slowly in extremities		Deep emotional wounding
	Pale complexion, anemia		Find excuses not to do something
	Always feeling cold (hands, feet, extremities)		Lack of movement in life, not driven
	High Blood Pressure		Deep emotional issues
	Low Blood Pressure		Lack of love in life, feel unloved
	Heart issues; Heart palpitations		Jealous, envious
	Absent-minded, forgetful		Feel alienated or lonely
	Teeth & Gum Issues		Feel wishy-washy about making decisions

## IMMUNE

<b>"X"</b>	<b>Physical</b>	<b>"X"</b>	<b>Emotional</b>
	Chronic illness		Unresolved emotions
	General weakness		Stuck or entangled emotions
	Extreme fatigue		Exhausted from giving to others
	Frequent cold sores, viral issues		Something eating away at you, and making you bitter
	Earaches		Not want to hear what people are saying, or surrounding turmoil (arguments)
	Sore throat, laryngitis		Not able to express self or speak up for self

## GLANDULAR

<b>"X"</b>	<b>Physical</b>	<b>"X"</b>	<b>Emotional</b>
	Blood sugar issues (diabetes, mood, etc.)		Loss of joy and sweetness in life
	Craving for sugar		Abandonment
	Adrenal fatigue		Loss of empowerment
	Thyroid, underactive		Lack of self-confidence
	Thyroid, overactive		Hysteria, paranoia

**REPRODUCTIVE**

<b>“X”</b>	<b>Physical</b>	<b>“X”</b>	<b>Emotional</b>
	Excessive periods		Resentment
	Scant or little periods		Oppressed
	PMS cramping, bloating, discomfort		PMS mood swings
	Menopausal issues, hot flashes, night sweats		Situation burning you up, not feel wanted
	Loss of sexual desire		Frigidity; Hard time connecting with someone else
	Hard time being intimate		Not love self
	Infertility		Not able to receive, feel worthless
	Prostate issues		Feel responsible to take care of others
	Impotence (Erectile Dysfunction)		Guilt

**NERVOUS**

<b>“X”</b>	<b>Physical</b>	<b>“X”</b>	<b>Emotional</b>
	Stress affecting quality of life, nervous tension		Hypersensitive
	Low energy levels		Boredom, lack of motivation
	Fatigue in the afternoon		Over-responsible and dutiful
	Waking up frequently at night		Self-blame
	Startle easily, jumpy		Suspicious, not feel safe
	Insomnia – trouble getting to sleep		Mental chatter
	Insomnia – trouble staying asleep		Restless, on edge
	Anxiety, nervousness		Impatient
	Neuropathy		Hysteria

**STRUCTURAL (BONES, JOINTS, MUSCLES, HAIR, NAILS)**

<b>“X”</b>	<b>Physical</b>	<b>“X”</b>	<b>Emotional</b>
	Stiff, aching muscles, bones and/or joints in the front of the body		Not able to move forward
	Stiff, aching muscles, bones and/or joints in the back of the body		Not able to let go of the past
	Weak bones, osteopenia, osteoporosis		No support system
	Osteoarthritis; Mobility and flexibility issues		Rigid, inflexible, hard-headed, stubborn

<b>"X"</b>	<b>Physical</b>	<b>"X"</b>	<b>Emotional</b>
	Rheumatoid arthritis, fibromyalgia		Feel like a victim, everyone is out to get you
	Brittle fingernails		Not thriving or flourishing
	Alopecia, losing hair		Obsessive, compulsive
	Skin pigmentation, scarring, discoloration		Loss of identify, loss of individualism

**LIFESTYLE QUESTIONS**

<b>General Questions</b>	<b>Yes/No answers</b>
How many ounces of water do you drink a day?	_____ ounces
List any prescriptions you are currently taking:	
List any herbs and vitamins you are currently taking:	
What time to you get to bed on average?	
Have you ever used Aromatherapy before?	
If so, what have you used it for, and what were the results?	

**ADDIITONAL COMMENTS**