

# Wellness Consult

Reach your wellness goals!

Essential oil reference book/app: \_\_\_\_\_

## 1 Write down your health priorities and find solutions.

| Top Health Priorities for You and Your Family | 90-Day Goals | Natural Solutions You Have or Need |
|---|--------------|------------------------------------|
| 1.  |              |                                    |
| 2.  |              |                                    |
| 3.  |              |                                    |

## 2 Create your Daily Wellness Plan.

Take the solutions you identified above and organize them into your daily plan.

| MORNING  | AFTERNOON   | EVENING  |
|--|---|--|
|  |   |  |
|  |   |  |
|  |   |  |
| <b>Daily Wellness Habits</b><br><input type="checkbox"/> 1-3 drops Lemon oil in glass of water<br><input type="checkbox"/> 2 drops Frankincense on bottoms of feet or under tongue<br><input type="checkbox"/> 2 drops dōTERRA Balance® on neck or bottoms of feet | <input type="checkbox"/> 1-3 drops Lemon oil in glass of water<br><input type="checkbox"/> Diffuse 4-5 drops dōTERRA On Guard®<br><input type="checkbox"/> Apply Deep Blue® Rub after workout | <input type="checkbox"/> 2 drops Frankincense on bottoms of feet or under tongue<br><input type="checkbox"/> 2 drops dōTERRA Balance® on neck or bottoms of feet<br><input type="checkbox"/> Apply Deep Blue® essential oil where needed<br><input type="checkbox"/> Diffuse 3-5 drops Lavender at bedtime |

## 3 What other wellness choices could support your goals?

(e.g. increase water, sleep, exercise, dietary changes)

## How can you redirect your spending and replace everyday household items with more natural, high-quality dōTERRA products?

(e.g. skin, hair, laundry, cleaning)

## 4 Live empowered with natural solutions.

Create a 90-day wellness plan by adding the product(s) you need to your LRP orders (recommended to run before the 15<sup>th</sup>).

| MONTH 1 LRP  | MONTH 2 LRP  | MONTH 3 LRP  |
|--|--|--|
| Date: <input type="text"/> / <input type="text"/> / <input type="text"/> | Date: <input type="text"/> / <input type="text"/> / <input type="text"/> | Date: <input type="text"/> / <input type="text"/> / <input type="text"/> |
| _____  | _____  | _____  |
| _____  | _____  | _____  |
| _____  | _____  | _____  |
| _____  | _____  | _____  |
| _____  | _____  | _____  |
| TOTAL PV _____   | TOTAL PV _____   | TOTAL PV _____   |