Client's Information for Ear Candling

Name:____Date:____________________________
Address (City, State, Zip):____
Email: ____Phone:____
Referred or recommended by: ____

What is your general condition of health? GOOD_____FAIR_____POOR_____

Have you had any serious illness? YES NO

If YES, please specify____

Have you had any perforations of the ear drums, surgeries, bleeding from the ears, chronic ringing in the ears, equilibrium problems (balance) ? ____

Are you currently being treated by a doctor, chiropractor, or other practitioner? YES NO

If YES, please specify: ____

Do you wear a hearing aid? YES NO

Have you ever had an Ear Candling or cleaning? YES NO If YES, when?____

Symptoms (Check all that apply):

Ear aches_____ Ear discharge_____ Hearing loss_____ Excessive ear wax_____ Swimmer's ear_____ Headaches_____

Migraines_____ Sinus issues_____ Allergies_____ Sore throat_____ Ringing in the ears_____ Vertigo_____

Primary goal/concern for ear candling? ____

I certify that the above information is correct to the best of my knowledge. I will not hold the therapist responsible for any errors or omissions that I have made in the completion of this form. I understand the ear candling service is designed to be a health aid and is in no way to take the place of a doctor's care. Information exchanged during the ear candling session is educational in nature and should be used at my own discretion. All client information is held in strict confidence. Ear Candling is an Old Home Remedy. The person receiving this therapy assumes full responsibility. The manufacturer or sellers are not liable for any claims, costs, or damages resulting from use of the candles.

Signature: ____ Date: ____________________________ _