

**Client's Information
(Ear Candling)**

Name _____ DOB _____ Date _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Work Phone _____ E-mail address _____

Referred by: _____

Any Current Health Conditions _____

Are you taking any medication _____

Do you wear a hearing aid _____ Have you ever had an ear cleaning _____

Primary goal/concern for Ear Candling _____

Symptoms (Check if you have had any of the following)

Ear Aches

Headaches

Ear Discharge

Sinus problems

Loss of hearing

Allergies

Excessive ear wax

Ringing in ears

Swimmer's ear

Dizziness

I certify that the above information is correct to the best of my knowledge. I will not hold the Ear Candler 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 any Ear Candling session is educational in nature and should not be considered a diagnosis.

Signature _____ Date _____

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