NAME_____ DATE ___/___/___

ADDRESS _____APT # _____

CITY _____ STATE_____ ZIP _____

HOME PHONE # (___)_____ DATE OF BIRTH _____

WORK PHONE # (___)_____ OCCUPATION _____

Referred or Recommended by: _____

What is your general condition of health? Good ___ Fair ___ Poor ___

Have you had any serious illness? Yes ___ No ___ If yes, what? _____

Are you currently being treated by a doctor, chiropractor or other practitioner? Yes ___ No ___

If so, for what? _____

Do you wear a hearing aid? Yes ___ No ___ Have you ever had an ear cleaning? Yes ___ No ___

Primary goal/concern for Ear Candling_____

_____

SYMPTOMS Check symptoms you currently have or have had in the past.

- Ear Aches
- Ear Discharge
- Loss of Hearing
- Excessive Ear Wax
- Swimmer's Ear
- Headaches
- Migraine Headaches
- Sinus Problems
- Allergies
- Sore Throats
- Ringing in ears
- 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 when it is indicated. Information exchanged during any Ear Candling session is educational in nature and should be used at your own discretion. All Client information is held in strict confidence.

This is a Old Home Remedy. The person receiving the Ear Candling assumes full responsibility. The Manufacturer or Sellers are not liable for any claims, costs or damages resulting from use of the Candles.

Signature _____ Date _____