CLIENT EAR CANDLING INFORMATION

Name _____ Date_____

Address_____ Apt #_____

City _____State _____ Zip _____

Contact Phone # _____Email _____

How did you hear about Body Basics? _____

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

Are you currently being treated by a doctor or other practitioner? _____

If yes, What for? _____

Do you wear a hearing aid? Yes____ No ____ Have you ever had an ear cleaning? Yes____ No _____

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

Ear Aches _____ Swimmers Ear _____ Allergies _____Ear Discharge _____

Headaches _____ Sore Throats_____ Loss of Hearing _____ Dizziness _____

Migraine Headaches _____ Ringing in the Ears _____ Sinus Problems _____

Excessive Ear Wax _____

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 completetion of this form. I understand the Ear Candling service is designed to be a health aid and is no way to take 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 an old home remedy. The person receiving the Ear Candling assumes full responsibility. Body Basics and the Ear Candling therapist are not liable for any claims, costs or damages resulting from Ear Candling. The manufacturer or sellers are not liable for any claims, costs or damages resulting from use of the candles.

Signature _____ Date _____