Ear Candling Client's Chart Therapist: _____

Client's Name	Today's Date	
Address	City	Postal Code
Fax:	E-Mail:	
Home Phone	Work Phone	
Date of Birth	Occupation	
Referred by	Family Doctor	
Reason for Treatment:		
Have you had ear candling done before? When? Where?		
Under medical treatment now? If yes; please give us some details:		
List of Current Medications & Supplements:	List Environmental & Drug Allergies:	
How would you rate you present current health condition? Excellent Good Poor		
Are you currently being treated by other practitioners?		

Do you wear a hearing aid? Have you ever had your ears cleaned before?

Check off any of the symptoms you are currently experiencing or have experienced in the past:

Ear Aches	Swimmer's Ear	Allergies	Sore Throats
Ear Discharge	Headaches	Migraines	Sinus Problems
Loss of Hearing	Ringing in Ears	Buzzing	Snoring
Excessive Ear Wax	Sinusitis	Dizziness	Balance Problems
Ear Tubes	Punctured Ear Drum	Sinus Infections	Ear Infections

Disclaimer: The ear candle practitioner does not make any claim of replacing any holistic or medical therapy. This therapy is of a complimentary nature only, rather than a curative treatment in itself. 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 treatment assumes full responsibility. The manufacturer or sellers of the candles are not liable for any claims, costs or damages resulting from the use of the candles.

I certify that the above information is correct to the best of my knowledge. I will not hold the Ear Candler responsible for any results or for any errors or omissions that I have made in the completion of this form. I understand that this service is designed to be a health aid and in no way takes the place of a doctor's care when it is indicated.

Client's Signature of Consent for Treatment:
_____

Visual Examination of Ears:	Out Come:	Follow Up:
2nd Appointment		
3rd Appointment		

Visual Examination of Ears:

Date: Visual Examination of Ears:	Outcome	Follow Up:
Date: Visual Examination of Ears:	Outcome	Follow Up:
Date: Visual Examination of Ears:	Outcome	Follow Up:
Date: Visual Examination of Ears:	Outcome	Follow Up:

Date: Visual Examination of Ears:	Outcome	Follow Up:
Date: Visual Examination of Ears:	Outcome	Follow Up: