KAS-SKY
Wholistic Health Care Centre

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EAR CANDLING RECORD

CONTACT INFORMATION

Name (surname): _____ (given): _____

Address: _____

Phone (home): _____ (work): _____

Email: _____ Mobile: _____

Date of Birth (year/month/day): _____ Date: _____

How did you hear about us: ☐ Website ☐ Yellow Pages ☐ Signage ☐ Family ☐ Friend ☐ Co-worker ☐ Live in the area

Introduced by: _____ Case recorded by: _____

PATIENT INFORMATION

What is your general health condition? ☐ Good ☐ Fair ☐ Poor

Have you had any serious illness? If yes, specify. ☐ Yes ☐ No

_____

Do you wear a hearing aid? ☐ Yes ☐ No

Have you ever had an ear cleaning by a doctor? ☐ Yes ☐ No

Have you had ear surgery in the past? ☐ Yes ☐ No

Do you have, or ever had tubes in your ears within the past year? ☐ Yes ☐ No

Reason for booking an ear candling treatment: _____

_____

PATIENT SYMPTOMS

☐ Ear Aches	☐ Swimmer's Ear	☐ Allergies	☐ Ear Discharge	☐ Sinus Problems
☐ Sore Throats	☐ Hearing Loss	☐ Migraines	☐ Dizziness	☐ Ringing in Ears
☐ Excessive Ear Wax	☐ Headaches			

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 that Ear Candling is designed to be complementary to orthodox healing practices and is in no way to take the place of a doctor's care when it is indicated. Information exchanged during an Ear Candling session is educational in nature and should be used at your own discretion. All client information is held in strict confidence.

Signature: _____ Date: _____