THE HEALING BRIDGE CHIROPRACTIC CLINIC

Ear Candling Client Form

Name: _____ Date: _____

Address: _____ Email Address: _____

_____ Phone Number: _____

Postal Code: _____ Birth Date: _____

Medical History:

Medications: _____

Surgery: _____

Illnesses: _____

General Condition of Health: Good ( ) Fair ( ) Poor ( )

Have you ever had ear candling? Yes ( ) No ( )

Primary goal/concern for ear candling: _____

_____

Symptoms:

Please check symptoms that you are currently experiencing or have experienced in the past.

( ) Ear Aches
( ) Ear Discharge
( ) Loss of Hearing
( ) Excessive Ear Wax
( ) Sinus Problems
( ) Swimmer's Ear
( ) Headaches
( ) Dizziness
( ) Ringing in Ears
( ) Sore Throats
( ) Allergies
( ) Chinook Headaches
( ) Migraine Headaches

I certify that the above information is correct to the best of my knowledge. I will not hold the Ear Candling Practitioner responsible for any errors or omissions that I have made in the completion of the form. I understand that the ear candling service is designed to be a health aid and is in 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.

Signature: _____