Always In Touch, LLC
Ear Candling Client Information Sheet

Name: ____

Today's Date: ______________________________________

Address: ____

City: ______________________ **State:** _____________ **Zip:** ___________________

Date of Birth: _______________ **Email Address:** _____________________________

Phone Number: ____

Referred or Recommended By: ____

What is the general condition of your health? ____________________________________

Are you being treated for any medical or ear related issues? _______________________

If yes, please explain: ____

Do you wear a hearing aid? _______________ **Have you ever had an ear candling?** ______________

Primary goal/concern for your ear candling session for today:

____

Circle any symptoms you are currently having/have had:

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

I certify that all the above information is correct to the best of my knowledge. I will not hold the Practitioner responsible for any errors or omission 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 no way to take the place of a doctor's care when it is indicated. Information exchanged during my 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. The manufacturer or sellers are not liable for any claims, cost or damages resulting from the use of their ear candles.

Signature: ____ **Date:** ___________________________