Utopic Therapeutic Massage & Skin Care, LLC

Ear Candling

Name:_____ Birthday:___/____

Address:_____City:_____State: _____Zip: _____

Phone Number:(___)_____Referred By:_____

Email Address (if you want to receive monthly specials):_____

What is your general condition of your health (please circle)? Good Fair Poor

Have you had any serious illness (please circle)? Yes No If yes, what?_____

Are you currently being treated by a doctor, chiropractor or other practitioner (please circle)? Yes No
If so, what for?_____

Do your wear a hearing aid (please circle)? Yes No

Have you ever had an ear cleaning (please circle)? Yes No

Primary goal/concern for Ear Candling? _____

_____

Symptoms
Please circle symptoms you currently have or have had in the past

Ear Aches	Swimmers Ear	Allergies
Ear Discharge	Headaches	Sore Throats
Loss of Hearing	Migraine Headache	Ringing in ears
Excessive Ear Wax	Sinus Problems	Dizziness

I certify that the above information is correct to the best of my knowledge. I will not hold Utopic responsible for any errors or omissions that I have made in the completion of this form. I understand that the Ear Candling service is designed to be a health aid and is in no way to take the 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 a Old Home Remedy. The person receiving the Ear Candling assumes full responsibility. The Manufacture or Sellers are not liable for any claims, costs or damages resulting the use of the Candles.

Client Signature:_____ Date:_____