Ear Candling History Questionnaire

Back to Essentials
A Complete Health and Wellness Center

Please **PRINT, ANSWER**, and **FILL IN ALL** the questions/blanks listed in this form. Date_____/_____/20_____

Full Name (First, Middle Initial, and Last) _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ (H) _____ (W) _____

Email Address _____

Occupation _____Place of Employment_____

Height _____ Weight _____ DOB _____ Age _____

Sex _____ Marital Status _____

Emergency Contact: Name _____

Relationship _____ Phone _____ Alt Phone _____

Physician _____ Phone _____

Is your physician aware of you receiving Ear Candling? _____

Please state your expectations from Ear Candling? _____

_____

CONTRAINDICATIONS: Please check YES or NO for EACH question.

YES	NO	
		Have you recently had ear surgery? If so, when? _____
		Have you had a recent head or neck injury? If so, what type and when? _____ _____
		Do you have any tumors of the ear?
		Do you have a perforated eardrum?
		Do you have an artificial eardrum?
		Do you have cysts in the ears?
		Do experience ear drainage?
		Do you have ear tubes presently?
		Have you ever been diagnosed with Mastoiditis? If so, when? _____
		Have you ever experienced any other ear conditions?

If you have answered "yes" to any question above, please explain. _____

I UNDERSTAND THAT IF I ANWSERED "YES" TO ANY OF THE QUESTIONS ABOVE, I MUST CONSULT WITH MY MEDICAL DOCTOR PRIOR TO EAR CANDLING.

I, _____ (print name), certify that I HAVE NOT BEEN DIAGNOSED WITH ANY CONTRAINDICATIONS FOR USE OF EAR CANDLING.

CONSENT AND RELEASE

I, _____ (client's printed name), certify that I AM OVER 18 YEARS OF AGE, OR I AM THE FATHER/MOTHER/LEGAL GUARDIAN OF _____ (minor's printed name). I HAVE FULLY DISCLOSED MY MEDICAL HISTORY AND HAVE COMPLETELY AND ACCURATELY ANSWERED ALL HEALTH RELATED QUESTIONS. I WILL ALERT *Back To Essentials, LLC* OF ANY CHANGES TO MY HEALTH, MEDICATIONS AND/OR LIFESTYLE AS THEY OCCUR.

I UNDERSTAND THAT I MUST CONSULT WITH MY MEDICAL DOCTOR IF I HAVE ANY AFOREMENTIONED MEDICAL CONDITIONS.

I AM UNDERGOING TREATMENT(S) ON MY OWN FREE WILL. I UNDERSTAND THAT ALTHOUGH EVERY PRECAUTION WILL BE TAKEN TO PREVENT COMPLICATIONS, THEY CAN AND SOMETIMES OCCUR. IF I EXPERIENCE ANY DISCOMFORT, I AM RESPONSIBLE FOR STOPPING MY SESSION AND IMMEDIATELY NOTIFYING THE THERAPIST. I ACCEPT FULL RESPONSIBILITY FOR ANY COMPLICATION THAT MAY OCCUR AND HEREBY ABSOLVE *Back To Essentials, LLC* AND ITS ASSOCIATES/STAFF/AFFILIATES OF ANY BLAME FOR ANY COMPLICATIONS RESULTING FROM MY TREATMENTS.

THIS FACILITY DOES NOT CLAIM TO TREAT ANY CONDITION OF DISEASE. I UNDERSTAND THAT *Back To Essentials, LLC* PROVIDES THE FACILITY, EQUIPMENT, AND INSTRUCTIONS FOR THE SELF-ADMINISTERING OF THE INFRARED SAUNA. FOR RECEIVING INSTRUCTIONS AND SESSIONS HERE, I RELEASE AND FOREVER DISCHARGE *Back To Essentials, LLC* AND ITS ASSOCIATES/STAFF/AFFILIATES FROM ANY AND ALL RESPONSIBILITY OR LIABILITY ARISING FROM THESE PROCEDURES. NO GUARANTEES OR WARRANTIES HAVE BEEN MADE TO ME OR TO THE SUCCESS, VALUE, OR BENEFITS OF SUCH PROCEDURES.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENT. I HAVE READ, UNDERSTAND, AND AGREE WITH THE INFORMATION PRESENTED TO ME. I DECLARE THE INFORMATION I HAVE DISCLOSED HEREIN TO BE TRUE AND ACCURATE.

Client's Signature _____ Date _____/_____/20____

Guardian's Signature _____Date _____/_____/20____
*For Clients under 18 yrs old, the signature and attendance of the parent or guardian is required. *

Who can we thank for referring you? _____