Suzi's Skin Care Studio LLC.

Ear Candling Release Form

_______________________   ____________________
Name   *Date*

____
Address   *City/State*   *Zip*   *Contact #*

____
Birthday   *Email*   *Referred By*

____
Dermatologist   *Phone #*   *Date of 1st Visit*

1. What is your general condition of health? Good______ Fair______ Poor______

2. Medications: ____

3. Allergies: ____

4. Please inform us of any of the following problems you are experiencing with your hearing:
____

5. Are you currently being treated by a doctor, chiropractor or other practitioner?
____

6. Do you wear a hearing aid? Yes / No
7. Have you ever had an ear cleaning? Yes / No

8. Primary goal/concern for ear candling:
____

Circle symptoms you are currently experiencing or have in the past:

Ear aches   Ear discharge   Loss of hearing   Excessive Ear Wax

Swimmer’s Ear   Headaches   Migraine Headaches   Sinus Problems

Allergies   Sore Throats   Ringing in the ears   Dizziness