

EAR CANDLING CLIENT INFORMATION

Name: _____

Address: _____

Phone: _____ Doctor: _____

Date of birth: _____ Describe your general health: _____

Medical History: Have you ever had a serious ear infection? ____ If so, when? _____

Do you have trouble regulating internal pressure in your ears or clearing your ears? (eg. when in an airplane) _____

Do you have Post-nasal drip? ____ Catarrh (sinus inflammation/mucous)? ____ Headaches? ____ Migraines? ____

Do you have problems with sinus infections? ____ How often and how severe? _____

Do you sometimes have sinus congestion? ____ Vertigo? ____ Imbalance? ____ Ringing in the ears? ____

Do you have frequent ear, nose or throat infections? ____ If so, how often? _____

Do you have Meniere's syndrome? ____ Do you wear a hearing aid? ____ If so, for how long? _____

Do you have an allergy to bees? ____ Any other allergies? (please list) _____

Congenital hearing loss? ____ Conductive deafness? ____ Nerve deafness? ____

Acquired hearing loss? ____ If so, how & when did your hearing loss occur? _____

Do your ears feel plugged-up? ____ Do your ears often feel "itchy" inside? _____

Do you clean your ears with a Q-tip? ____ Have you been exposed to long periods of excessive noise? _____

Do you usually have an excessive build-up of ear wax? ____ Do you have sensitive auditory ear canals? ____

CONTRAINDICATIONS **Have you ever had?**

Ear surgery ____ Cysts in ear ____ Ear drains/tubes ____ If so, when? _____

Mastoiditis in acute phase ____ Osteosclerosis ____ Ankylosis of Stapes ____ Paracentesis ____

Are you now under a doctors care for any ear conditions? ____ If so, what is the reason? _____

GENERAL HEALTH: High blood pressure: ____ High cholesterol ____ Diabetes ____

Asthma ____ Bronchitis ____ Pregnant ____ Skin Problems ____ Do you have an ear ache today? ____

What medications are you taking? _____

Do you suffer from any disorder or disease? If so, what? _____

Why are you having this ear candling session today? _____

Have you ever had an ear candling treatment? _____ Have you ever had a massage? _____

I understand that this ear candling session is for the purpose of ear hygiene, relaxation, restoring equilibrium, regulating internal pressure of the ears and for relief of pain or congestion caused by headaches, sinusitis or rhinitis (colds). Ear wax (cerumen) can collect in the auditory ear canal and impair hearing because it blocks sound waves. Ear candling is not a cure for the above named symptoms and will not restore hearing loss caused by nerve deafness. I understand that there is no guarantee that conductive hearing loss will be restored. I have been advised of the possible side-effects from an ear candling session (eg. light-headedness, ear tenderness & redness). I have been advised to keep my ears protected from the wind and out of the water for 24 hours after treatment today.

Signed: _____ Date: _____

For Office Use Only

Date: _____

OTOSCOPE EXAM

Ear Candling Session Number: _____

Client Name: _____

Right Ear Otoscope Exam

Ear canal is clean and healthy. _____ Some redness observed within ear canal _____
Ear infection? _____ Ear canal appears swollen _____ Ear drum clearly visible _____
Some ear wax within auditory canal _____ Ear wax covers tympanic membrane _____
Color of ear wax _____ Size & shape of auditory ear canal _____
Other observations _____

Left Ear Otoscope Exam

Ear canal is clean and healthy. _____ Some redness observed within ear canal _____
Ear infection? _____ Ear canal appears swollen _____ Ear drum clearly visible _____
Some ear wax within auditory canal _____ Ear wax covers tympanic membrane _____
Color of ear wax _____ Size & shape of auditory ear canal _____
Other observations _____

CANDLING OBSERVATIONS:

FIRST CANDLE (RIGHT EAR) Otoscope _____
Observations & Client Comments: _____

SECOND CANDLE (RIGHT EAR) Otoscope _____
Observations & Client Comments: _____

FIRST CANDLE (LEFT EAR) Otoscope _____
Observations & Client Comments: _____

SECOND CANDLE (LEFT EAR) Otoscope _____
Observations & Client Comments: _____

RECOMMENDED FOR SUBSEQUENT CANDLING SESSION? _____

RECOMMENDED THERAPIES? _____

RECOMMENDED PRODUCTS? _____

NEXT APPT. DATE: _____

CLIENT COMMENTS:

