CLIENT CONSULTATION FORM
EAR CANDLING

Name	Date
Address	Client No.
	Referred by
	email
Date of Birth	
	Mob
Tel	

Presenting Condition			Contraindications/Precautions		
(Tick where applicable)	Y	N	Perforated eardrums	Y	N
Sinus/rhinitis			Ear grommets or tubes		
Headaches			Cochlea implant		
Migraines			Infectious diseases/disorders		
Earaches			Eczema/dermatitis/infections in outer ear		
Tinnitus			Acute/infectious disease		
Glue Ear			High temperature/fever/ heavy cold		
Excess/compacted wax			Recent Head or neck injuries		
Catarrh			Under influence of alcohol or drugs		
Hay Fever			High/low blood pressure		
Colds			Toothache/dental work		
Sore Throats			Oil in ear		
Snoring			Allergies to ear candle treatment		
Pressure problems			Recent Operations/scar tissue		
Menieres disease			Cysts/lumps		
Other (notes below)			Serious medical conditions		
			Other (specify below)		

Disclaimer

I have answered the questions truthfully. I understand the therapist has gone through this consultation with me, to identify if there are any contra-indications that would affect me having a treatment. I also understand that this is to safeguard me as well as the therapist. I therefore do not hold the therapist KAMILA GLASEK liable.

Client Signature ……………………………………………………

Client to print name ……………………………………………….

Kamila Glasek IHM Tel: 07726402702 email: info@kenbiki.co.uk

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Feedback/Comments about your treatment

What was the treatment like?
How do you feel like now?
Would you recommend it?

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