CONFIDENTIAL

HOPI EAR CANDLING
CONSULTATION FORM

SECTION A - *Complete this section if you are a new customer, or if you have NOT filled out this section on another consultation form previously.*

Name:

Mobile:

Landline:

Email:

Occupation: *(optional)*

DOB: *(optional)* Age: *(optional)*

Doctor/GP: *(optional)*

GP Address: *(optional)*

Address:

Height: *(optional)* Weight: *(optional)*

Do you Smoke? Y ☐ N ☐ Daily Quantity:

GP Tel: *(optional)*

SECTION B - *Please complete this section*

What is the reason for your treatment?

Presenting Conditions *(Tick all that apply):*

☐ Sinus ☐ Rhinitis ☐ Headaches ☐ Migraines ☐ Ear Aches ☐ Tinnitus

☐ Glue Ear ☐ Excess Wax ☐ Compacted Wax ☐ Catarrh ☐ Hay Fever ☐ Colds

☐ Sore Throats ☐ Snoring ☐ Meniere's Disease ☐ Pressure Issues ☐ Other *(please explain below)*:

If you have any other health condition please explain:

Please thoroughly complete the "Medical Background" sections below, as certain medical conditions may affect your Hopi Candling treatment. Please include any relevant information in the "Additional Information" section on the following page.

Medical Background A *(Contraindicated - Tick all that apply)*

Skin Issues - including Dermatitis, Acne, Eczema, Psoriasis, Skin Allergies, Skin Infections to outer ear/face/scalp. *(briefly explain):*

Yes ☐ No ☐

Perforated Ear Drums *(briefly explain):*

Yes ☐ No ☐

Ear Grommets or Tubes *(briefly explain):*

Yes ☐ No ☐

Cochlear Implants *(briefly explain):*

Yes ☐ No ☐

High Temperature / Fever / Heavy Cold *(briefly explain):*

Yes ☐ No ☐

Toothache / Dental Work *(briefly explain):*

Yes ☐ No ☐

Medical Background B *(Tick all that apply):*

Muscular System - including injuries, ache or pain in muscles and joints *(briefly explain):*

Yes ☐ No ☐

Skeletal System - including injuries, fractures, arthritis *(briefly explain):*

Yes ☐ No ☐

Circulatory System - including heart, angina, thrombosis, varicose veins, fluid retention, family history *(briefly explain):*

Yes ☐ No ☐

Blood pressure - including hypertension, hypotension, medication, stable, unstable *(briefly explain):*

Yes ☐ No ☐

Lymphatic System - including swelling in lymph glands, tonsils, adenoids, frequent infection *(briefly explain):*

Yes ☐ No ☐

Respiratory System - including bronchitis, asthma, sinusitis, ear infections, cough *(briefly explain):*

Yes ☐ No ☐

Nervous System - including headaches, migraine, tension, stress, anxiety depression *(briefly explain):*

Yes ☐ No ☐

Cancer - including diagnosis, date, treatment, medication, prognosis, remission, family history *(briefly explain):*

Yes ☐ No ☐

Allergic Reactions - including triggers e.g. medication, supplements, food, additives, beeswax, products *(briefly explain)*

Yes ☐ No ☐

Diabetes - including stable, unstable, diet or medically controlled, family history *(briefly explain):*

Yes ☐ No ☐

Operations - including dates, locations, scarring *(briefly explain)*

Yes ☐ No ☐

Medications - including prescribed, supplements, over the counter *(briefly explain):*

Yes ☐ No ☐

Additional Information:

SECTION C - *Complete this section if you are a new customer, or if you have NOT filled out this section on another consultation form previously.*

Please provide us with two contacts in case of an emergency. Thank you.

	EMERGENCY CONTACT 1		EMERGENCY CONTACT 2
Name:		Name:	
Mobile:		Mobile:	
Town:		Town:	
Relationship to you:		Relationship to you:	

SECTION D - *Please complete this section*

By signing this document, I attest to the truthfulness and completeness of the information provided in this form /consultation, to my therapist regarding my health. I hereby declare that I have not withheld any information that may affect the outcome of the treatment. The treatment has been fully explained and I have been made aware of any possible reactions which could occur. I hereby indemnify therapist, **Denise Coleman** against any adverse reactions that I may feel are sustained as a result of the treatment.

I give permission to this therapist to hold my records: **A)** to best deliver their services ☐ **B)** to confirm appointments ☐ *(Please tick both boxes)*

I acknowledge that typing my name below constitutes my electronic signature and signifies my consent to the terms and conditions outlined above.

Client Signature: **Date**:

Please complete the form and either email it to info@denisecoleman.com or bring a printed copy to your initial appointment. Failure to do so may result in the inability to proceed with treatment.