Ear Candling Consent – Austin Acupuncture

Client Name:		DOB:		Date:	

Presenting Condition/s	✔	Since When - Date
Relaxation		
Sinus / Rhinitis		
Headaches / Migraines		
Ear Ache		
Tinnitus		
Glue Ear		
Excess / Compacted Wax		
Catarrh		
Hay Fever		
Colds		
Sore Throats		
Snoring		
Pressure Problems		
Meniere's Disease		
Other (describe)		

Precautions / Contraindications	✔
Perforated Ear Drums	
Ear Grommets or Tubes	
Cochlear Implants	
Infections to Outer Ear. Face, Scalp	
Eczema, Dermatitis, Skin Disorders	
Acute Infectious Diseases	
Temperature, Heavy Cold or Flu	
Recent Head or Neck Injures	

Precautions / Contraindications	✔
Under Influence of Alcohol or Drugs	
High or Low Blood Pressure	
Toothache or Dental Work	
Oil or Drops in ear (past 48 hours)	
Allergies (to candle ingredients)	
Recent Operations or Scar Tissue	
Cysts, Lumps or Bumps	
Bruising, Cuts, Abrasions or Sunburn	

Serious Medical Conditions (describe)

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Medications		
Drug Name	**What Is It For**	**Date**

Notes

Consent

I (the patient) confirm these details are correct and that to my knowledge I have not withheld any information that may be relevant to my treatment. I consent to treatment as discussed and agreed between myself and my therapist, or; I am the legal guardian and I consent to my charge having treatment as discussed and agreed between myself and the therapist.

I confirm that I have been told about potential side effects and have been given a patient information form.

Client Signature: _____

Therapist Signature: _____

How did you hear about Austin Acupuncture: _____