Hopi Ear Candle Treatments – Consultation Form

Name: Date of Birth:	Address:
Tel (Day): Tel (Eve):	

REASON FOR VISIT:

Date:

ARE YOU ON ANY MEDICATION?

Aspirin: **Antibiotics:** **Migraleve/ Migravess/ Migril:**

Other:

Heart problems?	**Blood pressure:**
Prone to infections:	**How many antibiotics in last 12 months:**

EARS: Do you have a perforated ear drum? YES ( ) NO ( ) If yes how long?
Deafness: Left/ scale 1 – 10 ( ) Right/ scale 1 – 10 ( )
WAX: Left ( ) Right ( ) Ear syringed? Yes ( ) No ( ) If yes when was last time? ( )
Earache: Left ( ) Right ( ) Frequency............................. Duration:..........................
Have you put oil in your ears? ( ) When?........................
TINNITUS: Left / Right/ Both SOUND: Ringing / Buzzing / Other
Scale 1 – 10 ( ) When did it start? Years ( ) Months ( ) Weeks ( )
Cause?..

SINUSES: Left / Right / Nose / Eyes / Cheeks **How often:..................Duration:.....................**	**Colds: How often..........................** **Duration: Severity:** **SORE THROATS:** **Duration: Severity:**
HAYFEVER / RHINITIS **How often: Duration:**	**RESPIRATORY: Asthma:** **How often: Severity:**

TENSION HEADACHES: Frequency: Duration:
Medication:...
MIGRAINE: Frequency Duration:
Severity scale 1 – 10 ( ) Vomiting etc:
Medication:...

VERTIGO / M..NI»RS / LABYRINTHITIS: Left ( ) Right ( ) Severity 1 – 10 ( )
Duration: Last attack:
Medication:

BACK / NECK PROBLEMS?
DETAILS:

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ALLERGIES: **Herbs:** **Honey:** **Other:**	**SMOKE: YES ( ) NO ( )** **How many per day?** **SKIN: Dry ( ) Sensitive ( )** **Eczema ( ) Psoriasis ( )**

DAIRY PRODUCE: Daily intake:

Tea: **Cups per day ( )**
Coffee: **Cups per day ( )**
Alcohol: **Units per day ( )**
Water: **Litres per day ( )**

ANY INFORMATION NOT COVERED?

To my knowledge I have / have not had a perforation of either ear drum and therefore take full responsibility for the Ear Candle treatment to be carried out, I have had the procedure satisfactorily explained to me.

Signed:.. Date:..

Comments following treatment:

Burning time LEFT EAR ( ) Burning time RIGHT EAR ( )

2nd Treatment (approx 3 – 7 days) Date:...
How have you felt since the last treatment – dairy product intake?

Comments following treatment:

Burning time LEFT EAR ( ) Burning time RIGHT EAR ( )

3rd Treatment (.........Days) Date:...
How have you felt since last treatment?

Comments following treatment:

Burning time LEFT EAR ( ) Burning time RIGHT EAR ( )

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