# Valley Massage Therapy
# Ear Candling Consent Form

Date: _____

Name: _____

*Questionnaire:*

Have you ever experienced a professional ear candling session? ☐ Yes ☐ No
*If so,* what did you enjoy most and least about the candling?

What results are you looking for as a result of your session today?

*Health Related:*

Are you presently under a Doctor or Therapist's care? ☐ Yes ☐ No

*If so, why?* _____

Do you wear any type of hearing aid? ☐ Yes ☐ No

Check the following symptoms that you have or had previously experienced:

☐ Ear Aches ☐ Headaches ☐ Ringing in Ears ☐ Ear Discharge ☐ Migraines

☐ Dizziness ☐ Loss of Hearing ☐ Sinus Infections ☐ Excessive Ear Wax ☐ Allergies

☐ Swimmer's Ear ☐ Sore Throats ☐ Other _____

Do you have any general health concerns that may be relevant to your session today?

_____

*Consent Agreement*

I understand that the ear candling session given here is for the purpose of stress reduction, health aid or for increased circulation and energy flow. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals. It has been made clear to me that this session is not a substitute for medical examination and/or diagnosis and it is recommended that I see a physician for any physical ailments I may have. I have stated all my known medical conditions on this form and/or on the Medical Health History Form and take it upon myself to keep the massage therapist updated on my physical health. By signing the release, I do hereby waive and release the massage therapist from all liability, past, present and future.

Signature: _____ Date: _____

*Consent to Treatment of Minor*

By my signature below, I hereby authorize a Licensed Massage Therapist to administer ear candling techniques to my child or dependent, as they deem necessary.

Signature: _____ Date: _____