



www.novamedspa.com

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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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Headaches | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> Migraines | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Sinus Infections | |
| <input type="checkbox"/> Excessive Ear Wax | <input type="checkbox"/> Allergies | |
| <input type="checkbox"/> Swimmer's Ear | <input type="checkbox"/> Sore Throats | |
| <input type="checkbox"/> 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/aesthetician does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist/aesthetician 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/aesthetician updated on my physical health. By signing the release, I do hereby waive and release the massage therapist/aesthetician 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 / Board Certified Aesthetician here at The Medical Spa at Nova to administer ear candling techniques to my child or dependent, as they deem necessary.

Signature: _____ Date: _____