Client Intake

Name_____ Date of Birth_____
Address_____
City_____ State_____ Zip Code_____
Home Phone(___)_____ Work Phone(___)_____
Cell Phone(___)_____E-mail Address_____
Referred By_____ Phone(___)_____
Emergency Contact_____ Phone(___)_____

Is this your first ear coning experience?_____ If you answered no, when was your last treatment?_____
Please explain your reason for having ear coning today:_____

Please take a moment to read the following information:

I understand that the ear coning session I receive is provided for recreational purposes and relaxation. Ear coning is not to be used as a medical treatment for any ailment I may have. If I experience any pain or discomfort during this and future sessions, I well immediately inform the practitioner to end the session. I further understand that ear coning should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment in full of the scheduled appointment. I also understand that **if I cancel or do not show to any future appointment without at least 24 hours notice, I am responsible for payment in full.** I will be charged the amount of the service to be rendered, and it will be due in full within three (3) days of the missed appointment.

Name (printed) _____ Date_____

Signature_____