Purple Dawn Healing

Therapeutic Remedial Trigger Point Therapy Myofascial release Ear Candling

Personal Details

Date: _____

Your personal information is kept strictly confidential and only used for contact purposes.

Name: Dr / Mr / Mrs / Miss / Ms Ally Murray DOB: _____

Address: _____

Phone: (daytime) _____ Occupation: _____ Email: _____

Are you a smoker: Yes / No

Medical History

Do you have or have you ever had:

Asthma	Yes / (No)	Hearing Difficulties	(Yes) / No as child
Sinus Problems	(Yes) / No	Haring loss	Yes / (No)
Hay Fever	(Yes) / No	Buzzing/ Ringing noises	(Yes) / No - 5 times per yr.
Coughs/ Colds	(Yes) / No	Itching of Ears	(Yes) / No
Sore throat	(Yes) / No	Irritations in ear	(Yes) / No
Bronchitis	(Yes) / No	Pain during high altitudes	(Yes) / No
Headaches	(Yes) / No	Sense of imbalance	(Yes) / No
Migraines	(Yes) / No	Ear infections	(Yes) / No
Sleeplessness	(Yes) / No	Glue ear/ Swimmers ear	Yes / (No)
Neck Pain	(Yes) / No	Perforated ear drum	Yes / (No) Approx date: _____
Stress/ Anxiety	(Yes) / No		

Do you swim regularly Yes / (No) How often? few times a year

Water is your water consumption, in glasses per day? 6 - 10 +

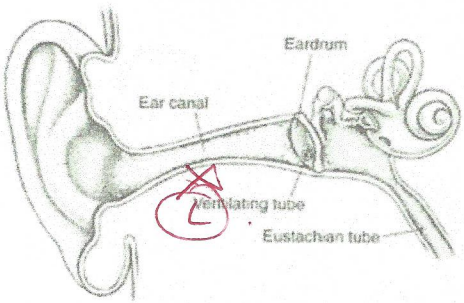
Do you exercise (Yes) / No How? walking, Karate

Do you have any other health conditions that require mentioning, as they may affect your treatment? -

Are you currently taking medication for your ears? Yes / (No) What? _____

Any other medication? Metformin

What is your present complaint? Sore egg ears.



Description: ache.

Mark area where client is feeling pain at the moment.

18 Colyer St Crookwell NSW 2583
p:0400 440 034