Confidential Medical History and Waiver

For Services Rendered by **ENERGETIC ALLERGY RELEASE, LLC. (EAR)**

NAME of CLIENT **Printed** _____ TODAY'S DATE _____

DATE OF BIRTH _____ NAME of LEGAL GUARDIAN (If applicable) _____

PLEASE PRINT ALL INFORMATION BELOW

HOME STREET ADDRESS: _____

CITY _____ STATE/PROVINCE _____ ZIP/COUNTRY _____

TELEPHONE _____ (____) _____ CELL _____(____) _____

E-MAIL ADDRESS _____ OCCUPATION _____

NAME OF EMERGENCY CONTACT _____ PHONE _____

PLEASE DESCRIBE YOUR MEDICAL HISTORY AND/OR HEALTH CONCERNS:

PLEASE LIST PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

PLEASE INITIAL HERE _____ INDICATING YOU UNDERSTAND **ALL SESSIONS MUST BE COMPLETED.**

SELF OR LEGAL GUARDIAN: By signing below I agree everything stated above is true and accurate and I will not hold **EAR** financially or legally liable for any treatments, services or advice provided to me and/or (of applicable) my dependents. I understand the unpredictable nature of allergies and related symptoms and that **EAR**, like all medical professionals, cannot guarantee results. **EAR** cannot guarantee new allergies will not develop in the future. I assume all responsibility for unpredictable immune reactions, which may lead to increased symptomology. In this event, I agree to seek immediate medical attention. I understand **EAR** does not treat cases of anaphylaxis and agree to fully disclose all information regarding life-threatening allergies or allergies resulting in anaphylaxis prior to or following the start of my treatment.

PLEASE INITIAL HERE _____ INDICATING YOU UNDERSTAND **EAR** LIKE ALL HEALTH PROFESSIONALS CANNOT GUARANTEE RESULTS.

WHO RECOMMENDED YOU TO **EAR'S** SERVICES? _____

THIS IS VITAL. YOUR SIGNATURE BELOW IS YOUR AGREEMENT TO THE ABOVE TERMS AS WELL AS AGREEMENT TO NOT DISCLOSE **EAR** FEES OR YOUR OUTCOME TO THE PRESS OR MEDIA.

YOUR SIGNATURE (To be signed in the presences of **EAR.)** _____