Confidential Medical History and Waiver

For Services Rendered by **Absolute Allergy Relief, LLC. (AAR)**

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:

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 **AAR** 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 **AAR**, like all medical professionals, cannot guarantee results. **AAR** 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 **AAR** 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 **AAR** LIKE ALL HEALTH PROFESSIONALS CANNOT GUARANTEE RESULTS.

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

YOUR SIGNATURE BELOW IS YOUR AGREE TO THE ABOVE TERMS AS WELL AS YOUR AGREEMENT TO NOT DISCLOSE **AAR** FEES AND NOT SAY ANYTHING TO THE PRESS OR MEDIA ABOUT YOUR OUTCOME. Please… THIS IS VITAL.

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