A.R.E. HEALTH CENTER & SPA
HEALTH RELEASE FORM
PLEASE PRINT

Name_____ Date of birth_____
(Signed parental consent and release form required if under 18)

Address_____
City/State/Zip_____
Phone( )_____ E-mail _____
The Health Center can send news (discounts, new services, etc.) via your e-mail address.
How did you hear about us? Word of mouth_____ ARE website___ Print ad?_____ Internet site?_____ Other?_____
Detail on your discovery of the spa helps us spend wisely on advertising!
Please fill in the information requested below. All information will be kept confidential.

Do you have now, or have you ever had, any of the following?

NO YES/ WHEN?

___ _____ **ABDOMINAL PROBLEMS What kind? _____**
___ _____ **ALLERGIES (Specify any kind, especially peanut or olive oil)_____**
___ _____ **ARTHRITIS**
___ _____ **BACK PROBLEMS___UPPER___MIDDLE___LOWER**
___ _____ **CANCER What kind? _____**
___ _____ **DIABETES**
___ _____ **DISLOCATIONS/ FRACTURES Where? What kind? _____**
___ _____ **EDEMA (Persistent swelling)**
___ _____ **GOUT**
___ _____ **HEADACHES**
___ _____ *** HEART PROBLEMS What kind? _____**
___ _____ **HEPATITIS circle one A B C D**
___ _____ **HERNIA What kind_____**
___ _____ ***HIGH BLOOD PRESSURE ____ Controlled by medication**
___ _____ **HYPOGLYCEMIA (Low blood sugar)**
___ _____ *** KIDNEY DISEASE**
___ _____ **LOW BLOOD PRESSURE**
___ _____ **LYMPHEDEMA or LYMPH NODE REMOVAL What area? _____**
___ _____ **MUSCLE CRAMPING**
___ _____ **NECK PROBLEMS What kind?_____**
___ _____ **NEUROLOGICAL DISEASES___M.S. ___PARKINSON'S___OTHER**
___ _____ **OSTEOPOROSIS**
___ _____ **SKIN PROBLEMS___Rashes___Eczema___Psoriasis___Other:_____**
___ _____ **SURGERY What area? What kind? _____**
___ _____ **TMJ (Diagnosed jaw dysfunction)**
___ _____ **VARICOSE VEINS What area? _____**
___ _____ **RECENT INJURIES/ACCIDENTS___Motor Vehicle___X-rays taken**
___ _____ **AREAS OF NUMBNESS, WEAKNESS, SHOOTING PAINS IN ARMS OR LEGS**
___ _____ **DO YOU HAVE ANY CONTAGIOUS DISEASES?____Herpes____AIDS____OTHER**
___ _____ ***ARE YOU PREGNANT? How many months?_____**
___ _____ **OTHER HEALTH PROBLEMS OR THINGS YOU WOULD LIKE US TO KNOW ABOUT YOU?_____**

***SOME HYDROTHERAPIES (STEAM/FUMES, WHIRLPOOLS, AND EPSOM SALTS BATHS) SHOULD HAVE A DOCTOR'S APPROVAL IF THESE CONDITIONS ARE PRESENT.**

THIS REQUEST FOR INFORMATION DOES NOT IMPLY, IN ANY WAY, THE PRACTICE OF MEDICINE OR DIAGNOSIS OF A CLIENT'S CONDITION BY ANY MASSAGE THERAPIST OR STAFF MEMBER OF THE A.R.E. HEALTH CENTER. THE HEALTH CENTER RESERVES THE RIGHT TO RESTRICT SERVICE TO, OR DECLINE ACCEPTANCE OF, THE CLIENT.

THIS IS TO CERTIFY THAT I AM REQUESTING SERVICES ON MY OWN INITIATIVE AND I REALIZE THAT A.R.E. HEALTH CENTER & SPA DOES NOT DIAGNOSE AILMENTS OR PRESCRIBE TREATMENTS. I RELEASE THE A.R.E. HEALTH CENTER, ITS STAFF, AND THE A.R.E. FROM ANY LIABILITY FOR CLAIMS RESULTING FROM THE USE OF ITS SERVICES.

SIGNATURE_____DATE_____

Name _____DATE _____

Please select your preferences below:

Type of Therapy:

- ☐ Massage
- ☐ Foot Reflexology
- ☐ CranioSacral

Therapist Gender:

- ☐ Male
- ☐ Female
- ☐ No Preference

Pressure:

- ☐ Gentle
- ☐ Moderate
- ☐ Firm
- ☐ Moderate/Firm