



## Ionic Foot Bath Intake Form

### Personal History

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Phone Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Birth Date MMDDYY: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Marital Status: Married Single Widowed Divorced Separated  
Business/Employer: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Email Address: \_\_\_\_\_  
How did you hear about the Ionic Foot Bath? \_\_\_\_\_  
Have you ever had an Ionic Foot Bath? \_\_\_\_\_

### Current Complaints: List any diseases and medications you are taking

1. \_\_\_\_\_ Onset of condition \_\_\_\_\_  
Medications \_\_\_\_\_  
2. \_\_\_\_\_ Onset of condition \_\_\_\_\_  
Medications \_\_\_\_\_  
3. \_\_\_\_\_ Onset of condition \_\_\_\_\_  
Medications \_\_\_\_\_

Additional medication, vitamins, and supplements you currently take

\_\_\_\_\_  
\_\_\_\_\_

### Do you suffer from any of the following?

- |   |   |
|---|---|
| <input type="checkbox"/> Poor Immune System (Susceptible to colds, flu, allergies, viruses etc) | <input type="checkbox"/> Digestive Problems   |
| <input type="checkbox"/> Candida/yeast/parasite infections                                      | <input type="checkbox"/> Joint Pain           |
| <input type="checkbox"/> Menopause Symptoms   | <input type="checkbox"/> Gout                 |
| <input type="checkbox"/> Poor Memory & Concentration  | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Skin Conditions i.e.: acne, eczema etc                                 | <input type="checkbox"/> Fever                |
| <input type="checkbox"/> Arthritis aches, rheumatoid, osteoarthritis                            | <input type="checkbox"/> Unbalanced PH levels |
| <input type="checkbox"/> Subjected to heavy metals, pesticides, toxins                          | <input type="checkbox"/> Fainting             |
| <input type="checkbox"/> Low/high blood sugar   | <input type="checkbox"/> Weight Problems      |
| <input type="checkbox"/> Low/high blood pressure  | <input type="checkbox"/> Inflammation         |
| <input type="checkbox"/> Anxiety/Depression   | <input type="checkbox"/> Poor Body Strength   |
| <input type="checkbox"/> Low Energy Levels  | <input type="checkbox"/> Stress               |
| <input type="checkbox"/> Poor Sleep   |   |
| <input type="checkbox"/> Menstrual Cramps   |   |

Family Doctor: \_\_\_\_\_ Does your MD know about these conditions? Y N

If yes, what type of treatment are you using? \_\_\_\_\_

What were the results of your treatments? \_\_\_\_\_

### Recommendations

- ✧ If taking medication, take at least 6 hours prior to or following the Ionic Foot Bath treatment
- ✧ Drink plenty of water prior to and during a session
- ✧ Do not use computer or cellular phone during a treatment
- ✧ People with low blood sugar levels should eat before the treatment
- ✧ Clean your feet properly prior to and following a session
- ✧ Remove all jewellery prior to your session

### Contraindications to Ion Cleanse – Please indicate any of the following that apply to you

- |  |   |
|--|---|
| <input type="checkbox"/> Have a pacemaker or any battery operated/electrical implant   | <input type="checkbox"/> Have had Chemo/radiation therapy     |
| <input type="checkbox"/> On heart beat regulating medications  | <input type="checkbox"/> On Blood thinning disease medication |
| <input type="checkbox"/> Pregnant or lactating   | <input type="checkbox"/> Under the age of 10                  |
| <input type="checkbox"/> Organ recipient   | <input type="checkbox"/> Have Type 1 Diabetes                 |
| <input type="checkbox"/> Epileptic   | <input type="checkbox"/> Have metal implants                  |
| <input type="checkbox"/> Have had organs removed, especially colon   | <input type="checkbox"/> Hypertension                         |
| <input type="checkbox"/> Have an open foot wound   |   |
| <input type="checkbox"/> Hemophilia  |   |
| <input type="checkbox"/> On medication, that in absence of which would mentally or physically incapacitate you (i.e.: psychotic episodes, seizures, etc) |   |
| <input type="checkbox"/> Have a medical condition, are on dialysis, or diagnosed with diabetes or congestive heart failure                               |   |

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

#### **Fees:**

**1 Session** - \$40.00 or **6 sessions** for \$210.00

**Annual Package** - \$770.00, consists of spring & fall cleanse plus 1 session/month for 10 months (22 sessions)

### Consent to Ion Foot Bath Session

I acknowledge that by participating on an Ionic Foot Bath session that no medical diagnosis can be made. I understand that the Ionic Foot Bath session I am receiving is not a substitute for normal medical care, and I should continue any present medical treatment and consult my regular medical doctor for treatment of any new or old illnesses. I further take responsibility for my own health and well-being.

I may stop the session at any time, either during the assessment or the treatment. Ionic foot bath technicians do not diagnose, prescribe medication for medical or psychological conditions or treat for specific conditions

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Witness Name