

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 - \$35.00 or **6 sessions** for \$180.00

Annual Package - \$660.00, 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