IN LINE FAMILY
CHIROPRACTIC

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Ionic Foot Bath Intake Form

Personal History

Name:______________________________ Address:______________________________
City:______________________________ Province: __________ Postal Code:______________
Phone Numbers :______________________________
Birth Date:___/___/_____ Age:_________ Marital Status Married Single Widowed Divorced Separated
Business/Employer:______________________ Occupation:______________________________
Work Number:______________________ 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, supplements you currently take

____
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Do you suffer from any of the following?

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

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 jewelry prior to your session

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

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

Name:______________________________ **Signature:**______________________________

Fees:

1 Session - $35.00 or **5 sessions** for $150.00
Annual Package - $540.00, consists of spring & fall cleanse plus 1 session/month for 10 months (18 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