Ionic Detox Therapy Foot Bath

Intake Form

Name: ____ Date: ____________________

Address: __________________________________ City: _______________ State: __________

Postal Code: __________ Phone (C):______________ (H):______________ (W):_____________

DOB: ___________ Age: ______ Email: ____

How did you hear about us? ____

Emergency contact:

Name: ______________________ Relationship: __________________ Phone:_______________

Indicate your main health concerns in order of importance to you:
1.____ Duration: _______________________
2.____ Duration: _______________________
3.____ Duration: _______________________
4.____ Duration: _______________________

List any medications you are taking:
1.____ Reason ___________________________
2.____ Reason ___________________________
3.____ Reason ___________________________
4.____ Reason ___________________________

Water consumption:

How much Daily? _________________________Type? __________________________________

Contraindications:

1. Are you pregnant? **YES / NO**
2. Do you have a pacemaker or any other battery operated/ electrical implant? **YES / NO**
3. Are you an organ transplant recipient or donor? **YES / NO**
4. Are you on medication that regulates your blood levels? (EX: Blood thinner) **YES / NO**

I, the undersigned, **consent** to the Ionic Detox Therapy Foot Bath treatment. I understand that these procedures are for the purpose of detoxification and are not intended to take place of medical care or medications. I clearly confirm that I do not have any contraindications to the Ionic Detox Therapy Foot Bath (as noted above). I understand that I can discontinue my treatments at any time. I understand that I take full responsibility for my own health and well-being and agree to pay my account in full after every treatment.

PRINT Client's Name: ____

Client’s Signature: ____________________________________Date:________________