IonCleanse® Foot Bath Release Form

Name: ____

Address: ____

City: ___________________________ State: ________ Zip: ________________

Telephone: ______________________ E-mail: ____________________________

Date of Birth: _________________ Age: ________ Male: ____ Female: ____

What are your major health concerns:____

What medications are you currently taking:_______________________________________

Employment: ____
(if retired, please list previous career field)

When is the last time you had something to eat (for hypoglycemics only)? _______________

Do you have a heart pacemaker or any other battery operated or electrical implant? YES / NO

Are you pregnant or breastfeeding? YES / NO

Are you on medications to prevent rejection of a transplanted organ? YES / NO

Are you on mental health medications? YES / NO
If so, do you have symptoms if you miss one or more doses? YES / NO

Are you on a blood pressure medication? YES / NO
Does your blood pressure increase if you miss one or more doses of your medication? YES / NO

Are you on blood-thinning medication such as Coumadin? YES / NO

Do you take medication for irregular heart beat? YES / NO

Are you currently taking a course of chemotherapy treatment? YES / NO

I certify that everything on this form is true and correct to the best of my knowledge.

Signature _________________________________ Date ___________________