ion Cleanse

Ion Cleanse Foot Bath Release Form

Name: ____

Address: ____

City: ________________________ **State**: ____________________ **Zip**: _____________________

Telephone: ________________________________ **E-mail**: ________________________________

Date of Birth: _______________________

Age: __________________ **Male**: _____________ **Female**: _______________

Your major health concerns: ____

____

Medications that you are currently taking: ____

____

Employment: ____

(If retired, please list previous career field)

When was the last time you have had something to eat (for hypo-glycemics 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 a blood pressure medication? YES / NO

Does your blood pressure increase if you miss one or more doses of your medication? YES

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**: _______________________