

Blissful Beginnings & Beyond
Client Information Form for
IONCleanse Foot Bath

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone# (Home) _____ (Cell) _____ Email _____

Preferred Method of Contact: ___ Home Phone ___ Email ___ Cellphone Do you want to receive text messages for appointment reminders and discount specials? ___ No ___ Yes (if yes, provide cellphone carrier co) _____

Occupation _____ Employer _____

Emergency Contact _____ Phone # _____ Relationship _____

Medications _____ Physician _____

Age _____ Birth Date _____ Referred By _____

Primary reason for appointment: _____

What are your major health concerns: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING THE APPROPRIATE ANSWER:

- | | | |
|-----|----|---|
| YES | NO | Do you have a heart pacemaker or any other battery operated or electrical implant? |
| YES | NO | Have you ever had surgery? |
| | | If YES, please describe _____ |
| 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? |
| | | If YES, please describe _____ |
| YES | NO | Have you had any broken bones or acute injury in the past 2 years? |
| | | If YES, please describe _____ |
| YES | NO | Are you on a blood-thinning medication such as Coumadin? |
| YES | NO | Are you epileptic or seizures? |
| YES | NO | Are you diabetic? |
| YES | NO | Do you have varicose veins, phlebitis or blood clots? |
| YES | NO | Do you have cardiac or circulatory problems? |
| YES | NO | Are you currently taking a course of chemotherapy or radiation treatment? |
| YES | NO | Do you take medicine for an irregular heartbeat? |
| YES | NO | Are you pregnant or breastfeeding? |
| YES | NO | Are you on blood pressure medication? |
| YES | NO | Does your blood pressure increase if you miss one or more doses of your medication? |
| YES | NO | Do you have any other medical condition I should be aware of? |
| | | If Yes, please describe _____ |

The IonCleanse is a part of a comprehensive health and wellness system and the information provided to you is solely for use as part of a self-improvement program. None of the information provided is intended to act as a substitute for medical advice, nor does it involve the diagnosis, prognosis, or prescription of remedies for the treatment or prevention of any disease or ailment.

I certify that everything on this form is true and correct to the best of my knowledge. I also understand that the IonCleanse is not a medical device and is not intended to diagnose, treat, cure or prevent any disease or ailment.

Signature _____ Date _____