**Integrated Body Health** IonCleanse® Release Form

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male:\_\_\_\_\_\_\_\_ Female: \_\_\_\_\_\_\_**

**What are your major health concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you on any medications? YES / NO**

**If so, what conditions are the medications treating? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employment or Past Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When is the last time you have had something to eat? ( if hypoglycemic ) \_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have a 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**

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Toxicity Assessment Form**

|  |  |
| --- | --- |
| Name: | Date: |
| Type of Detoxification Modality: IonCleanse by AMD | |

# Directions

1. Complete this form before beginning your detoxification modality.

# Quantitative Evaluation

Score: Rate the next questions on a scale of 1 – 10. 10 being severe/chronic problems

Frequency: Never = 0; Rarely =1; Sometimes/Circumstantial = 2; Almost Always = 3

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Emotional/Mental** | **Score** | **Freq.** |  | **Physical** | | **Score** | **Freq.** | |
| Stress |  |  |  | Joint pain | |  |  | |
| Depression |  |  | Inflammation | |  |  | |
| Anxiety |  |  | Constipation | |  |  | |
| Aggression |  |  | Diarrhea | |  |  | |
| Irritability or Anger |  |  | Numbness | |  |  | |
| Fatigue |  |  | Poor circulation | |  |  | |
| Foggy brain |  |  | Gout | |  |  | |
| Problems sleeping |  |  | Body odor | |  |  | |
| Memory problems |  |  | Congestion | |  |  | |
| Difficulty focusing |  |  | Acne/skin blemishes/liver spots | |  |  | |
| Additional conditions/symptoms not listed above | | |  | Additional conditions/symptoms not listed above | | | | |
|  |  |  |  |  | |  |  | |
|  |  |  |  | |  |  | |
|  |  |  |  | |  |  | |
|  |  |  |  | |  |  | |
|  |  |  |  | |  |  | |
| **Total Score Emotional/Mental** |  | ------ |  | **Total Score**  **Physical** | |  | ------ | |
| **Total Score (Emotional/Mental +**  **Physical)** | | | | |  | | |