Integrated Body Health **IonCleanse® Foot Bath 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 _____