



IONCLEANSE®

FOOT BATH
RELEASE FORM

PLEASE COMPLETE THIS FORM IN BLUE OR BLACK INK. IF YOU HAVE ANY QUESTIONS OR CONCERNS, DO NOT HESITATE TO ASK FOR ASSISTANCE. WE WILL BE HAPPY TO HELP.

(PLEASE PRINT)

NAME: _____ DATE OF BIRTH: _____ FEMALE MALE
(FIRST) (MI) (LAST)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ MOBILE PHONE: _____ OTHER PHONE: _____

WHICH DO YOU PREFER TO BE CONTACTED ON? HOME NUMBER MOBILE NUMBER OTHER

E-MAIL ADDRESS: _____ OCCUPATION: _____

WHAT ARE YOUR MAJOR HEALTH CONCERNS?: _____

WHAT MEDICATIONS ARE YOU CURRENTLY ON?: _____

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 A MEDICATION 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

PLEASE READ THE FOLLOWING AND SIGN BELOW

THE IONCLEANSE® IS 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.

DATE

SIGNATURE