Alkaline Therapy: Confidential Health History Form

Please **PRINT** and **ANSWER <u>ALL</u>** questions.

Date_____/_____/20_____

Full Name (First, Middle Initial, and Last) _____

Address _____City _____State _____ Zip _____

Cell Phone _____ (H) _____ (W) _____

Occupation _____Place of Employment_____

Height _____Weight _____ DOB _____ Age_____ SSN# _____

Are you under the care of a physician? _____ If so, name? _____

How did you hear about us? ----------

May we notify you of our specials by email: _____

What do you eat for breakfast? _____

What do you eat for lunch? _____

What do you eat for dinner? _____

Please check ALL that apply:

Do you eat/consume:

_____ White stuffs _____ Caffeine _____ Meat

_____ Dairy Products _____ Sweets _____ Processed Food

_____ Alcohol _____ Tap Water

What products do you use?

Soap: _____ Toothpaste: _____ Deodorant: _____

Water: _____ Lotion: _____ Make-up: _____

Hair Products: _____ Toilet Paper: _____ Nail Products: _____

(ICE) In Case of Emergency Contact: _____ **Phone:** _____

Is your physician aware of you receiving an Ionic Foot Bath? _____

Why have you decided to have an Ionic Foot Bath session(s)? Please check all that apply:

_____ Dr. Suggested or prescription _____ Ninth Amendment "right to self treat"

Please state your expectations from receiving an Ionic Foot Bath? _____

CONTRAINDICATIONS: Please check YES or NO for EACH question.

YES	NO	
		Do you have a pacemaker?
		Do you have any battery-operated or electrical implant?
		Do you take medication to regulate your heartbeat?
		Are you pregnant?
		Are you breastfeeding?
		When was the date of the last day of your last period?
		Have you ever had an organ transplant?
		Have you ever had an organ removed?
		Have you ever had your colon removed?
		Do you take medications for seizures?
		Do you take medications for psychotic episodes

If you have answered "yes" to any question above, please explain. _____

I, _____ (print name), certify that I HAVE NOT BEEN DIAGNOSED WITH ANY CONTRAINDICATIONS FOR AN IONIC FOOT BATH.

Consent and Release

I, _____ (client's printed name), certify that I AM OVER 18 YEARS OF AGE, OR I AM THE FATHER/MOTHER/LEGAL GUARDIAN OF _____ (minor's printed name). I HAVE FULLY DISCLOSED MY MEDICAL HISTORY AND HAVE COMPLETELY AND ACCURATELY ANSWERED ALL HEALTH RELATED QUESTIONS. I WILL ALERT *Back To Essentials, LLC* OF ANY CHANGES TO MY HEALTH, MEDICATIONS AND/OR LIFESTYLE AS THEY OCCUR.

I AM AWARE THAT I SHOULD NOT WEAR METAL, USE A COMPUTER OR CELLULAR PHONE DURING AN IONIC FOOT BATH SESSION.

I UNDERSTAND THAT I SHOULD EAT BEFORE AN IONIC FOOT BATH SESSION IF I HAVE LOW BLOOD SUGAR.

I UNDERSTAND THAT IF I FEEL ANY DISCOMFORT I AM NOT REMOVE MY FEET FROM THE IONIC FOOT BATH IMMEDIATELY.

I UNDERSTAND THAT IF I AM ON MEDICATION I SHOULD TAKE THEM AFTER OR FOUR HOURS PRIOR TO AN IONIC FOOT BATH.

I UNDERSTAND THAT I MUST CONSULT WITH MY MEDICAL DOCTOR IF I HAVE ANY MEDICAL CONDITIONS, I.E. DIALYSIS, DIABETES, CONGESTIVE HEART FAILURE, ETC.

I AM UNDERGOING TREATMENT(S) ON MY OWN FREE WILL. I UNDERSTAND THAT ALTHOUGH EVERY PRECAUTION WILL BE TAKEN TO PREVENT COMPLICATIONS, THEY CAN AND SOMETIMES OCCUR. IF I EXPERIENCE ANY DISCOMFORT, I AM RESPONSIBLE FOR STOPPING MY SESSION AND IMMEDIATELY NOTIFYING THE THERAPIST. I ACCEPT FULL RESPONSIBILITY FOR ANY COMPLICATION THAT MAY OCCUR AND HEREBY ABSOLVE *Back To Essentials, LLC* AND ITS ASSOCIATES/STAFF/AFFILIATES OF ANY BLAME FOR ANY COMPLICATIONS RESULTING FROM MY TREATMENTS.

THIS FACILITY DOES NOT CLAIM TO TREAT ANY CONDITION OF DISEASE. I UNDERSTAND THAT *Back To Essentials, LLC* PROVIDES THE FACILITY, EQUIPMENT, AND INSTRUCTIONS FOR THE SELF-ADMINISTERING OF THE IONIC FOOT BATH. FOR RECEIVING INSTRUCTIONS AND SESSIONS HERE, I RELEASE AND FOREVER DISCHARGE *Back To Essentials, LLC* AND ITS ASSOCIATES/STAFF/AFFILIATES FROM ANY AND ALL RESPONSIBILITY OR LIABILITY ARISING FROM THESE PROCEDURES. NO GUARANTEES OR WARRANTIES HAVE BEEN MADE TO ME OR TO THE SUCCESS, VALUE, OR BENEFITS OF SUCH PROCEDURES.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENT. I HAVE READ, UNDERSTAND, AND AGREE WITH THE INFORMATION PRESENTED TO ME. I DECLARE THE INFORMATION I HAVE DISCLOSED HEREIN TO BE TRUE AND ACCURATE.

Client's Signature _____ Date _____/_____/20_____

Guardian's Signature _____Date _____/_____/20____
*For Clients under 18 yrs old, the signature and attendance of the parent or guardian is required. *

Who can we thank for referring you?

_____CLIENT SIGNATURE **X**_____ Date _____/_____/_____
(*For clients 18 or under, the signature & attendance of the parent/guardian for insertion is required)*

I have reviewed this form with my client. Therapist Signature **X**_____

First Session Evaluation: YES/NO

Did Therapist review Health History and inquire about any health issues? _____

Were the device, area, supplies, room, and restroom clean? _____

Were your results satisfactory? _____

Will you recommend us to family/friends? _____

Did you have any problems/discomfort during session? _____

If so, please exlain:
_____

_____

How do you feel?
_____

CLIENT SIGNATURE X_____