Alternative Chiropractic Clinic
Box 6388
Wetaskiwin Alberta
Phone 780 352 6411

IonCleanse® Foot Bath Release Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ E-mail: _____

Date of Birth: _____ State of Birth: _____

Age : _____ Male: ____ Female: ____

What are your major health concerns:_____

What medications are you currently on:_____

Employment:
_____
(if retired, please list previous career field)

When is the last time you have 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 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

I certify that everything on this form is true and correct to the best of my knowledge.

Signature _____ Date _____