Wellness Concepts Clinic, LLC

Ionic Foot Detox Form

Date: _____

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-mail address: _____

May we email you specials and promotions? Yes_____ No_____

Single: ☐ No ☐ Yes Married: ☐ No ☐ Yes

What would you like to achieve from your treatment today?

_____

History

1) Have you ever had an ionic foot detox bath? ☐ No ☐ Yes, when? _____

2) Do you have Battery/Electrical powered devices inside the body? (pacemakers, pumps, etc.) ☐ No ☐ Yes

specify: _____

3) Have you ever had any organ transplants) ☐ No ☐ Yes

specify: _____

4) Do you have any heart disease or heart related health issues? ☐ No ☐ Yes

specify: _____

5) Do you have issues with Seizures? ☐ No ☐ Yes

6.) Do you have any damaged skin or open wounds near the treatment area? ☐ No ☐ Yes

List any medications/vitamins you take

_____

_____

Female Clients Only:

7) Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____

Minors:

_____ _____

Personal representative Printed **Personal representative signature**