

# Barefoot Therapy Ionic Foot Detox Consent Form

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## Personal Information

Name: \_\_\_\_\_ Phone:(day) \_\_\_\_\_ (evening) \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ DOB: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Email: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Veteran/Active Service    LEO/Dispatch    First Responder    Teacher    Minor Dependent of any of these

How did you hear about Barefoot Therapy?: \_\_\_\_\_

## General Information

Have you ever had an Ionic Foot Detox before?  Yes  No

If yes and you had an adverse reaction please describe it here along with approximate date: \_\_\_\_\_

Do you consume any of the following?

Coffee    Tea    Soda    Dairy    Meat    Grains    Sugar    Fried Food    Fast Food    Alcohol    Tobacco    Drugs

Are you currently being treated by a medical provider for a medical condition? If so, please explain along with name of the provider (if different than above). \_\_\_\_\_

## Contraindications

Ionic foot detoxes are not suitable for everyone. If you have any of the following conditions we recommend that you do not use the ion detox without your medical provider's written consent. If you have any other concerns regarding the use of the ion detox for health reasons we recommend that you also consult your medical provider.

Do you wear a pulse adjuster, pacemaker, metal, or any other electromagnetic device?  Yes  No

Have you had an organ(s) removed or received an organ transplant?  Yes  No

If yes, please list here along with dates: \_\_\_\_\_

Do you have hypertension?  Yes  No

Are you diabetic?  Yes  No

Do you have open wounds on your feet?  Yes  No

Are you currently receiving radiation or chemotherapy treatment for cancer?  Yes  No

Are you a blood cancer patient?  Yes  No

Do you have epilepsy?  Yes  No

Are you suffering from a fever?  Yes  No

Have you been diagnosed with any other serious illness?  Yes  No

If yes, please list here along with dates: \_\_\_\_\_

Have you had surgery within the last six weeks?  Yes  No

If yes, please list here along with dates: \_\_\_\_\_

Have you had any joints replaced with metal, or any other metal hardware place in your body?  Yes  No

If yes, please list here along with dates: \_\_\_\_\_

Are you pregnant or breastfeeding?  Yes  No

**Consent**

I, the undersigned, consent to the Ionic Foot Detox Treatment. I understand that this treatment is for the purpose of boosting my body's natural ability to detoxify itself and is not intended to take the place of medical care or medications. I confirm that I do not have any of the above contraindications or other concerns that I need to first consult with my medical provider, or that I have provided written consent from my medical provider. I understand that I take FULL responsibility for my own health and well-being. I release Barefoot Therapy and/or the Ionic Foot Detox Technician and the manufacturer from any liability regarding my health issues or treatment received.

\_\_\_\_\_  
Client name (print)

\_\_\_\_\_  
If a minor, Parent/Legal Guardian name (print) and relationship

\_\_\_\_\_  
Client/Parent/Legal Guardian signature Date