**IONCLEANSE® FOOT BATH RELEASE**

What are your major health concerns \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of medications are you taking currently \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant or breastfeeding? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a pacemaker or any other battery operated/electrical implant? \_\_\_\_\_\_\_\_\_\_\_\_

Are you on medications to prevent rejections of a transplanted organ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on mental health medications? \_\_\_\_\_\_\_ If so, do you have symptoms if you miss a dose? \_\_\_\_\_\_\_\_\_

Are you on blood pressure medications? \_\_\_\_\_\_\_ If so, do you have symptoms if you miss a dose? \_\_\_\_\_\_\_\_\_

Are you on blood thinning medications like Coumadin? \_\_\_\_\_\_\_ Irregular heart beat medications? \_\_\_\_\_\_\_\_\_

Are you taking any type of cancer treatment medications like chemotherapy? \_\_\_\_\_\_\_\_\_\_\_

Do you drink tap water? \_\_\_\_\_\_\_\_ Do you use plastic in the microwave? \_\_\_\_\_\_\_\_\_

Do you eat nonorganic? \_\_\_\_\_\_\_\_ Are the products you use on your skin solely organic? \_\_\_\_\_\_\_\_

Do you have exposure to industrial environments, warehouses, old buildings, military bases? \_\_\_\_\_\_\_\_\_\_

Do you exercise to the point of perspiration on a regular basis? \_\_\_\_\_\_\_\_\_\_\_\_

**Rate the questions on a scale of 0-10, 0= none 10= chronic/severe:**

Joint pain \_\_\_\_ Inflammation \_\_\_\_ Diarrhea \_\_\_\_

Stress \_\_\_\_ Insomnia \_\_\_\_ Anxiety \_\_\_\_

Fatigue \_\_\_\_ Numbness \_\_\_\_ Foggy Brain \_\_\_\_

Gout \_\_\_\_ Acid Reflux \_\_\_\_ Congestion \_\_\_\_

The IonCleanse® is part of a comprehensive health and wellness system and the information provided is solely for use as part of a self-improvement program. None of the following 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, or prevent disease or ailment.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT INTAKE FORM– MASSAGE THERAPY**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male/Female \_\_\_\_\_\_\_

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

How often do you receive professional massage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? \_\_\_\_\_\_ If so, how far along? \_\_\_\_\_\_\_\_\_\_\_\_\_ Any complications? \_\_\_\_\_\_\_\_\_\_\_

Are you under medical supervision? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you see a chiropractor? \_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_For treatment of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to oils, lotions, crèmes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you perform repetitive movements at work or sports? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience stress in your work, family, other areas in life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from muscles tension \_\_\_\_\_\_\_ anxiety \_\_\_\_\_\_\_ insomnia \_\_\_\_\_\_\_ irritability \_\_\_\_\_\_

Where in your body do you experience stiffness, pain, or discomfort? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your goals for today’s massage session? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following conditions:

( ) Contagious skin conditions ( ) Open sores or wounds ( ) Bruises easily ( ) DVT/blood clots

( ) Recent accident or injury ( ) Recent fracture ( ) Recent surgery ( ) Artificial joint

( ) Sprain/strain ( ) Current fever ( ) Cold/flu ( ) Swollen glands

( ) Allergies/sensitivity ( ) Heart condition ( ) Circulatory issue ( ) Varicose veins

( ) High/low blood pressure ( ) Atherosclerosis ( ) Phlebitis ( ) Osteoporosis

( ) Carpal tunnel syndrome ( ) Fibromyalgia ( ) Tennis elbow ( ) TMJ

( ) Arthritis/tendonitis ( ) Cancer ( ) Diabetes ( ) Migraines

( ) Back/neck problems ( ) Decreased sensation ( ) Infertility ( ) Seizures

Please explain any condition not listed above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension**. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and strokes may be adjusted to my level of comfort.** I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other medical specialist for mental or physical ailment that I am aware of. Because massage should not be performed under certain medical conditions, I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and there shall be no liability on the therapist’s part should I fail to do so.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist initials \_\_\_\_\_\_\_\_\_\_\_\_\_