Intuitive Self Healing
316 Bush Street
Red Wing, MN 55066

IonCleanse® Foot Bath Release Form

Name: ____

Address: ____

City: ___________________ **State:** ________________ **Zip:** __________________

Telephone: _________________________ **E-mail:** ____________________________

Date of Birth: _________________ **Age :** ________ **Male:** ____ **Female:** ____

What are your major health concerns:____

What medications are you currently on:____

Employment: ____

Do you have a pacemaker or any other battery operated/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 a 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. I understand that this system does not claim to cure or treat any disease or injury. It only assists the body to balance its energy fields and stimulates the body for self-detoxification.
I fully understand that those who counsel me are not medical doctors or practitioners and the services performed are at all times restricted to consultation on the subject of nutritional matters intended for the maintenance of the best possible state of nutritional health and do not involve the diagnosing, treatment, or prescribing of remedies for disease.

Signature _________________________________ **Date** ___________________