healthworks
chiropractic & wellness centre

357 King Street
Midland, Ontario L4R 3M7
Tel: 526-6900 Fax: 526-6460
www.healthworkscentre.com

Date: ....

Patient No: ....

Ionic Foot Bath Intake Form

Personal History

Name: ______________________ Address: ______________________

City: ______________________ Province: __________ Postal Code: __________

Home Phone Number: ______________________ Birth Date: _____/_____/_______ Age: __________
DD / MM / YEAR

Business/Employer: ______________________ Occupation: ______________________

Business Phone: __________ Gender ☐ Male ☐ Female Circle One: Married Single Widowed Divorced Separated

Cell Phone Number: ______________________ E-mail Address: ______________________

How did you hear about the Ionic Foot Bath? ______________________ Have you ever had an Ionic Foot Bath? __________

Current Complaints:

List any diseases and medications you are taking.

1. ______________________ Onset of Condition ______________________
   Medication: ______________________
2. ______________________ Onset of Condition ______________________
   Medication: ______________________
3. ______________________ Onset of Condition ______________________
   Medication: ______________________

Additional Medication, Vitamins, Supplements

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____

- ☐ Anxiety / Depression
- ☐ Arthritis Aches, Rheumatoid, Osteoarthritis
- ☐ Candida/Yeast/Parasite Infections
- ☐ Digestive Problems
- ☐ Fainting
- ☐ Fever
- ☐ Gout
- ☐ Headaches
- ☐ Inflammation
- ☐ Joint Pain
- ☐ Low Energy Levels
- ☐ Low/High Blood Pressure/Blood Sugar
- ☐ Menopausal Symptoms
- ☐ Menstrual Cramps
- ☐ Poor Body Strength
- ☐ Poor Immune System – susceptible to colds, flu, allergies, viruses, bacteria, etc.
- ☐ Poor Memory & Concentration
- ☐ Poor Sleep
- ☐ Skin Conditions e.g. acne, wrinkles, eczema etc.
- ☐ Stress
- ☐ Subjected to Heavy Metals, pesticides, toxins
- ☐ Unbalanced PH levels
- ☐ Weight Problems

Family Doctor: ______________________ Does your MD know about these condition? ☐ Yes ☐ No

If yes, type of treatment: ______________________

What were the results of your treatment: ______________________

Recommendations

- Strongly recommended to take a mineral and vitamin supplement after the session containing calcium, potassium sodium and magnesium preferably in liquid form as well as fatty acid, Vitamin C, vegetable juice or super foods such as Chlorella, Greens Plus+, Green phyto-power, etc.
- If taking medication, take at least 6 hours prior to Ionic Foot Bath or following treatment.
- Drink plenty of water prior to having Ionic Foot Bath and during the treatment.
- Do not use computer or cellular or portable phone during the treatment.
- People with low blood sugar levels should eat before the treatment.
- Clean your feet properly prior to and following treatment.

Contraindications to Ion Cell Cleanse

Please indicate any of the following that apply to you.

☐ Pacemaker or any battery-operated/electrical implant
☐ Heartbeat-regulating medication
☐ Pregnant or lactating
☐ Organ recipient
☐ Epileptic
☐ Type 1 Diabetes
☐ Hemophilia
☐ Open Foot Wounds
☐ Chemo/Radiation Therapy
☐ Blood thinning disease medication
☐ Children under 6
☐ Chemo/Radiation Therapy
☐ Hypertension
☐ Metal Implants
☐ Organs removed, especially the colon
☐ People who are on medication, the absence of which would mentally or physically incapacitate them, e.g. psychotic episodes, seizures, etc.
☐ Medical conditions or on dialysis or diagnosed with diabetes or congestive heart failure

Name________________________________ Initial______________

Consent to Treatment

I acknowledge that by participating in an Ionic Foot Bath treatment, that no medical diagnosis can be made. I understand that the Ionic Foot Bath treatment I am receiving is not a substitute for normal medical care, and I should continue any present medical treatment and consult my regular medical doctor for treatment of any new or old illnesses. I further take responsibility for my own health and well-being.

I may stop the session at any time, either during the assessment or the treatment. Ionic Foot Bath technicians do not diagnose, prescribe medication for medical or psychological conditions, or treat for specific conditions.

Dated this__________day of ______________, 20________.

______________________________ Patient Signature

______________________________ Verification of Signature (Witness)

______________________________ Print Name

______________________________ Print Witness Name

Office Use Only

☐ Standard Protocol

☐ Vitamin/Mineral Support or Antioxidant Support

☐ Naturopathic Consultation

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Ionic Foot Bath Treatment Plan

Name:

Cycle Time:	Cycle Start Date: Cycle Time:

	Meds	Jewels	Hydra	Food	Cell Ph.	Supm't	**Notes:** (Comments during, after or / and between baths).	
1							Water Intensity:	Colour: Reading
Date:								
2							Water Intensity:	Colour: Reading
Date:								
3							Water Intensity:	Colour: Reading
Date:								
4							Water Intensity:	Colour: Reading
Date:								
5							Water Intensity:	Colour: Reading
Date:								
6							Water Intensity:	Colour: Reading
Date:								
7							Water Intensity:	Colour: Reading
Date:								
8							Water Intensity:	Colour: Reading
Date:								
9							Water Intensity:	Colour: Reading
Date:								
10							Water Intensity:	Colour: Reading
Date:								
11							Water Intensity:	Colour: Reading
Date:								
12							Water Intensity:	Colour: Reading
Date:								
13							Water Intensity:	Colour: Reading
Date:								
14							Water Intensity:	Colour: Reading
Date:								

Re-evaluate Treatment Regime

Start Date for Next Cycle:______________________________