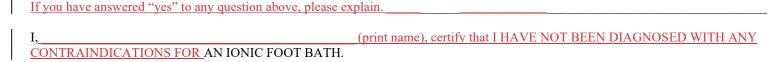
## Alkaline Therapy: Confidential Health History Form

Please PRINT an	d <u>ANSWER</u> <u>A</u>	ALL questions.					Date_	/	/20
Full Name (First,	Middle Initial	and Last)							
Address				City		State		Zip	
Cell Phone		(H)			(W)				
Occupation		Place of Employment							
Height	Weight_	DOB_	_Age_		SSN#				
Are you under the	e care of a phy	vsician? If	so, name? _						
How did you hear	r about us?								
May we notify yo	u of our speci	als by email:							
What do you eat	for breakfast	?							
What do you eat	for lunch? _								
What do you eat	for dinner? _								
Please check AL	L that apply:								
Do you eat/consu	me:	_ White stuffs		Caffeine		Meat			
		_ Dairy Products		Sweets		Processed	d Food		
		_ Alcohol		Tap Water					
What products d	lo you use?								
Soap:		Toothpast	e:			Deodor	rant:		
Water:		Lotion:				Make-ı	ւթ։		
Hair Products:		Toilet Pap	er:			Nail Pr	oducts: _		
(ICE) In Case of Emergency Contact:					Ph	one:			
Is your physician	aware of you	receiving an Ionic Foot	Bath?		_				
Why have you de	cided to have a	n Ionic Foot Bath sessi	ion(s)? Pleas	se check all th	nat apply:				
Dr. Suggested or prescription						Ninth An	<u>nendmen</u>	t "right to	self treat"
Please state your	expectations fr	om receiving an Ionic l	Foot Bath?						

## CONTRAINDICATIONS: Please check YES or NO for EACH question.

YES	NO

TED INC				
	Do you have a pacemaker?			
	Do you have any battery-operated or electrical implant?			
	Do you take medication to regulate your heartbeat?			
	Are you pregnant?			
	Are you breastfeeding?			
	When was the date of the last day of your last period?			
	Have you ever had an organ transplant?			
	Have you ever had an organ removed?  Have you ever had your colon removed?			
	Do you take medications for seizures?			
	Do you take medications for psychotic episodes			



## **Consent and Release**

I, (client's printed name), certify that I AM OVER 18 YEARS OF AGE, OR I AM THE FATHER/MOTHER/LEGAL GUARDIAN OF (minor's printed name). I HAVE FULLY DISCLOSED MY MEDICAL HISTORY AND HAVE COMPLETELY AND ACCURATELY ANSWERED ALL HEALTH RELATED QUESTIONS. I WILL ALERT Back To Essentials, LLC OF ANY CHANGES TO MY HEALTH, MEDICATIONS AND/OR LIFESTYLE AS THEY OCCUR.

I AM AWARE THAT I SHOULD NOT WEAR METAL, USE A COMPUTER OR CELLULAR PHONE DURING AN IONIC FOOT BATH SESSION.

I UNDERSTAND THAT I SHOULD EAT BEFORE AN IONIC FOOT BATH SESSION IF I HAVE LOW BLOOD SUGAR.

I UNDERSTAND THAT IF I FEEL ANY DISCOMFORT I AM NOT REMOVE MY FEET FROM THE IONIC FOOT BATH IMMEDIATELY.

I UNDERSTAND THAT IF I AM ON MEDICATION I SHOULD TAKE THEM AFTER OR FOUR HOURS PRIOR TO AN IONIC FOOT BATH.

I UNDERSTAND THAT I MUST CONSULT WITH MY MEDICAL DOCTOR IF I HAVE ANY MEDICAL CONDITIONS, I.E. DIALYSIS, DIABETES, CONGESTIVE HEART FAILURE, ETC.

I AM UNDERGOING TREATMENT(S) ON MY OWN FREE WILL. I UNDERSTAND THAT ALTHOUGH EVERY PRECAUTION WILL BE TAKEN TO PREVENT COMPLICATIONS, THEY CAN AND SOMETIMES OCCUR. IF I EXPERIENCE ANY DISCOMFORT, I AM RESPONSIBLE FOR STOPPING MY SESSION AND IMMEDIATELY NOTIFYING THE THERAPIST. I ACCEPT FULL RESPONSIBILITY FOR ANY COMPLICATION THAT MAY OCCUR AND HERBY ABSOLVE Back TO Essentials, LLC AND ITS ASSOCIATES/STAFF/AFFILIATES OF ANY BLAME FOR ANY COMPLICATIONS RESULTING FROM MY TREATMENTS.

THIS FACILITY DOES NOT CLAIM TO TREAT ANY CONDITION OF DISEASE. I UNDERSTAND THAT Back To Essentials, LLC PROVIDES THE FACILITY, EQUIPMENT, AND INSTRUCTIONS FOR THE SELF-ADMINISTERING OF THE IONIC FOOT BATH. FOR RECEIVING INSTRUCTIONS AND SESSIONS HERE, I RELEASE AND FOREVER DISCHARGE Back To Essentials, LLC AND ITS ASSOCIATES/STAFF/AFFILIATES FROM ANY AND ALL RESPONSIBILITY OR LIABILITY ARISING FROM THESE PROCEDURES. NO GUARANTEES OR WARRANTIES HAVE BEEN MADE TO ME OR TO THE SUCCESS, VALUE, OR BENEFITS OF SUCH PROCEDURES.

INFORMATION I HAVE DISCLOSED HEREIN TO BE TRUE AND ACCURATE. Date / /20 Client's Signature Guardian's Signature \*For Clients under 18 yrs old, the signature and attendance of the parent or guardian is required. \* Who can we thank for referring you? CLIENT SIGNATURE  ${f X}$ (For clients 18 or under, the signature & attendance of the parent/guardian for insertion is required) I have reviewed this form with my client. Therapist Signature  ${\bf X}$ **First Session Evaluation:** YES/NO Did Therapist review Health History and inquire about any health issues? Were the device, area, supplies, room, and restroom clean? Were your results satisfactory? Will you recommend us to family/friends? Did you have any problems/discomfort during session? If so, please exlain: How do you feel?

CLIENT SIGNATURE X

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENT. I HAVE READ, UNDERSTAND, AND AGREE WITH THE INFORMATION PRESENTED TO ME. I DECLARE THE