



# A Therapeutic Effect

## Personal Data

**Patient's Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_ **OK to leave message?**

\_\_\_\_\_ **preferred** **Y or N**

\_\_\_\_\_ **other** **Y or N**

**email:** \_\_\_\_\_

**How should we confirm your appointments? Automated Text and/or Automated Email (please circle)**

**Date of Birth:** \_\_\_\_\_ **Sex:** Male  Female  Transgender

month / day / year

**Occupation:** \_\_\_\_\_ **Referred by:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_ **OK to leave message?**

\_\_\_\_\_ **preferred** **Y or N**

**Relationship:** \_\_\_\_\_ **other** **Y or N**

Are you currently under a Physician's care? Yes No

If yes, please explain: \_\_\_\_\_

Please list and date any past or present injuries, accidents, or medical treatment including surgeries:

\_\_\_\_\_  
\_\_\_\_\_

Are you pregnant? Yes No **\*If yes, some services may not be administered.\***

Please list all known allergies: \_\_\_\_\_

Please list all medications and supplements you are taking: \_\_\_\_\_

### CANCELLATION POLICY

If you are unable to keep your appointment - for any reason - please give us as much notice as possible. For appointments broken with less than 24 hours notice, we reserve the right to charge 50% of the standard fee. Appointments that "no show" will be charged in full to cover the therapist's time.

**CONTRAINDICATIONS - If any of the following apply, Energetics™ OPTIMUM Ionic Foot Bath CANNOT be done**

Have Pacemaker or Other Electronic Device in your body

Are Pregnant or Nursing

Have an Organ Transplant

Are taking a Life Threatening Medication

**Please sign below to acknowledge that you have reviewed the contraindication list**

Client / Responsible Party Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PRECAUTIONS - If any of the following apply, consult your physician before using the Energetics™ OPTIMUM Ionic Foot Bath**

Have an Auto-Immune Disease

Have Epilepsy

Have a Liver Disease

Are taking any Medications, including Blood Thinners

**Please sign below to acknowledge that you have reviewed the precaution list**

Client / Responsible Party Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**If you feel uncomfortable at any time during a Foot Bath, simply remove your feet from the water.**

Remove and/or do not use electrical devices during the Foot Bath, such as cell phones, laptops, TV controllers, portable music players, watches. Also please remove jewelry and credit cards. These items interfere with the body's energetic field during the Foot Bath.

**Client Acknowledgment**

- I am aware that individual results may vary and no guarantees or promises have been made.
- I have reviewed the contraindications on this form and I am not subject to any of those conditions.
- I have consulted with my physician regarding any prescription drugs I am taking.
- I have consulted with my physician regarding any health concerns I have including those on the precautions list.
- I have answered truthfully all questions on this form.

I acknowledge that by participating in a Energetics™ OPTIMUM Foot Bath Treatment, I understand that no medical diagnosis can be made. I understand that the Energetics™ OPTIMUM Foot Bath Treatment I am receiving is not a substitute for 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.

Client's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Client's Printed Name: \_\_\_\_\_