Alora Health Spa

Patient Information – Ionic Foot Detox Bath

Name: _____ Date of Birth: ____/____/_____
Occupation: _____ Phone: _____
Email: _____
How did you find us? _____

Have you been under the care of a physician, dermatologist or other medical professional within the past year? Yes/No If yes, please explain: _____
Do you take any medication? Yes/No If yes, which ones? _____
_____
Do you have any allergies towards scented/unscented oils, lotions or creams? Yes/No If yes, please specify_____

Have you had or have cancer? Yes/No If so, what type? _____

Please circle if you suffer from any of the following:
Headaches (chronic)/Hormone imbalance/ Hepatitis/Systemic disease/Herpes/High blood pressure/Frequent cold sores/Spinal injury/Immune disorders/Thyroid condition/HIV/AIDS/ Hysterectomy/Lupus/Diabetes/Metal pins or plates/Heart problem/Phlebitis, blood clots, poor circulation/Varicose veins/Blood clotting abnormalities/Arthritis/Psychological treatment/Asthma/ Skin diseases/skin lesions/Eczema/Fever blisters/Epilepsy/Seizure disorder/Keloid scarring/ Insomnia/Any active infection:_____

Pulse rate: _____ Blood pressure: Low/Normal/High Cholesterol: Low/Normal/High

If female, are you pregnant? Yes/No If yes, how many weeks? _____
Any menopause challenges? Yes/No If yes, please list symptoms: _____
_____

Do you use any of the following and how often do you use them?
Cigarettes_____ Alcohol_____ Caffeine _____
Vitamins_____ Herbal Supplements _____ Aspirin_____

Do you eat fast foods, fatty foods, pre-prepared foods, or fried foods on a regular basis? Yes/No
Do you experience heart burn or ingestion after eating? Yes/ No
Do you feel sleepy after meals, bloated, and/ or gassy? Yes/No
Do you crave or eat sugary snacks, candies, or desserts? Yes/No
Do you drink coffee and sodas during the day to get yourself going? Yes/No
Do you exercise? Yes/No How often? _____
What is your daily consumption of water? _____
Do you have less than 2 bowel movements per day? Yes/No
What is your stress level? High / Medium / Low
Do you experience any problems sleeping? Yes/No
How many hours do you typically sleep each night? _____
Do you experience fatigue or low energy levels, especially around 3pm in the afternoon? Yes/No
Do you experience brain fog, lack of concentration and/or poor memory? Yes/No
Do you experience reoccurring yeast or fungal infections? Yes/No
Do you experience frequent headaches or migraines? Yes/No
Do you have arthritic aches and pains or stiffness? Yes/No
Do you live with or near polluted air, water, or any other environment pollution? Yes/No

Do you use fluoridated toothpaste or drink fluorinated/ chlorinated water? Yes/No
Do you experience depression or moods swings (mental highs or lows)? Yes/No
Do you have bad breath or excessive body odor? Yes/No
Do you have food allergies or bad skin? Yes/No
Are you showing signs of premature aging? Yes/No
Have you ever used an internal cleansing product or followed a complete internal cleansing program? Yes/No

In case of an emergency, whom should we call? Phone: _____
Relationship: _____ Name: _____

Please do not do this treatment:

- If you have a pacemaker or any other electronic implants
- Have open wounds on your feet
- Taking blood thinners
- Children under 8 years old

Only under doctor's supervision:

- If you have had an organ implant
- Pregnant or nursing
- Epilepsy
- Currently undergoing radiation or chemotherapy
- Hemophiliac

I understand and completed this questionnaire truthfully. I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindication and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform my therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release Alora Health Spa and/or the therapist from liability and assume responsibility thereof.

Signature_____ Date: _____

OFFICE USE ONLY

Notes:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Water Color
Black – Liver, Alcohol, Asthma
Grey – Heavy Metals
Brown – Liver, Tobacco, Fat, Waste
Green – Kidneys, Bladder, Urinary System, Feminine Problems
Light Green – Immune Systems
Orange – Arthritis, Rheumatism
White with Bubbles – Lymphatic System, Skin Allergies
White with Particles – Flatulence, Candida