Ion Spa Client Questionnaire

The Enhanced Living Ion Spa is capable of enhancing your overall health! When the body's toxin level is reduced, your body's systems and your overall physical condition will improve. Benefits include:

- Enhanced Blood Circulation
- Strengthened Immune System
- Activated Cell Tissues
- Enhanced Natural Detoxification
- Reduction in Skin Problems
- Enhanced Metabolism
- Improved Hormones
- Anti-aging
- Increased Energy
- Enhanced Absorption of Nutrients

Part I – General Information

Name: ____________________________________

Gender: ☐ Female / ☐ Male

Age: ☐ 15-25 / ☐ 26-49 / ☐ 50+

Address: ____________________________________

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E-mail: ____________________________________

Phone: ____________________________________

Please answer the following questions to ensure that you are suitable to use the Enhanced Living Ion Spa:		
Are you suffering from heart disease?	☐ Yes	☐ No
Do you wear a pacemaker or use a heartbeat-regulating machine?	☐ Yes	☐ No
Do you have any organ transplants? (Still under treatment)	☐ Yes	☐ No
Are you suffering from epilepsy?	☐ Yes	☐ No
Are you suffering from serious high/low blood pressure?	☐ Yes	☐ No
Are you suffering from any form of cancer?	☐ Yes	☐ No
Are you currently taking medicine?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Have you recently given birth?	☐ Yes	☐ No
Do you have any serious open wounds on your feet?	☐ Yes	☐ No

Part II – Medical Questionnaire

☐	Pimples	☐	Rheumatism	☐	Cold	☐	Coarse Skin	☐	Bladder
☐	Uterus	☐	Poor Memory	☐	Snoring	☐	Loose Skin	☐	Weakness of the Limbs
☐	Insomnia	☐	Dizziness	☐	Diabetes	☐	High Cholesterol	☐	Anemia
☐	Weakness of the Body	☐	Easily Irritated	☐	Obesity	☐	Hair Loss	☐	Liver
☐	Abdominal Distension	☐	Nervous	☐	Indigestion	☐	Alzheimer's Disease	☐	Cramps
☐	High Uric Acid	☐	Fatigue	☐	Poor Appetite	☐	Constipation	☐	Prostate Gland
☐	Heart Problem	☐	Respiratory System	☐	Muscle Pain	☐	Asthma	☐	Abdominal Pain
☐	Irregular Menstruation	☐	Edema	☐	Breast Cyst	☐	Lymphatic System	☐	Dental Problems
☐	Numbness of the Limbs	☐	Arthritis	☐	Kidney	☐	Fatty Acid	☐	Migraine

If your condition is not stated above, please list it here ____________________________________

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Therapist's Signature: ____________________________________

Date ______________________ Next Treatment Date/Time: ______________________