



Advanced Integrated Healthcare LLC

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IonCleanse® Foot Bath Release Form

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **E-mail:** _____

Date of Birth: _____ **Age:** _____ **Male:** ____ **Female:** ____

What are your major health concerns: _____

What medications are you currently on: _____

Employment:

(If retired, please list previous career field. Example: Dentist, Steelworker, Accountant, etc.)

When is the last time you have had something to eat? (For Hypoglycemic persons only)

Do you have a heart pacemaker or any other battery operated or electrical implant?
YES / NO

Are you pregnant or breastfeeding? YES / NO

Are you on medications to prevent rejection of a transplanted organ? YES / NO

Are you on mental health medications? YES / NO

If so, do you have symptoms if you miss one or more doses? YES / NO

Are you on a blood pressure medication? YES / NO

Does your blood pressure increase if you miss one or more doses of your medication? YES / NO

Are you on blood-thinning medication such as Coumadin? YES / NO

Do you take medication for irregular heart beat? YES / NO

Are you currently taking a course of chemotherapy treatment? YES / NO

I certify that everything on this form is true and correct to the best of my knowledge.

Signature _____ **Date** _____

Health History

Please list all previous surgeries and dates: _____

Please list all current medications: _____

Please indicate if you have experienced any of the following in the past year:

<input type="checkbox"/> fractured bones	<input type="checkbox"/> neck pain/stiffness	<input type="checkbox"/> numbness/tingling
<input type="checkbox"/> auto accidents	<input type="checkbox"/> jaw pain/click (TMJ)	<input type="checkbox"/> foot trouble
<input type="checkbox"/> other accidents	<input type="checkbox"/> fall(s)	<input type="checkbox"/> chest pain
<input type="checkbox"/> arthritis	<input type="checkbox"/> heart problems	<input type="checkbox"/> stroke
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> diabetes	<input type="checkbox"/> varicose veins
<input type="checkbox"/> seizures	<input type="checkbox"/> shoulder pain	<input type="checkbox"/> liver trouble
<input type="checkbox"/> arm/hand trouble	<input type="checkbox"/> dizziness	<input type="checkbox"/> circulation problems
<input type="checkbox"/> gall bladder trouble	<input type="checkbox"/> skin problems	<input type="checkbox"/> heartburn
<input type="checkbox"/> headaches/migraines	<input type="checkbox"/> cancer	<input type="checkbox"/> depressed or anxiety
<input type="checkbox"/> irritability	<input type="checkbox"/> ringing in ears	<input type="checkbox"/> hearing loss
<input type="checkbox"/> allergies	<input type="checkbox"/> frequent colds/flu	<input type="checkbox"/> trouble sleeping
<input type="checkbox"/> vision problems	<input type="checkbox"/> upper back pain	<input type="checkbox"/> low back pain
<input type="checkbox"/> mood swings/fatigue	<input type="checkbox"/> PMS	<input type="checkbox"/> hip pain
<input type="checkbox"/> ear infections	<input type="checkbox"/> sinus problems	<input type="checkbox"/> constipation
<input type="checkbox"/> diarrhea	<input type="checkbox"/> high stress levels	<input type="checkbox"/> leg pain

Other: _____

Of the above symptoms, which is your major complaint(s)?

Signature _____ Date _____