Touched By Grace
Lose the pain.....Find your life.

Health Questionnaire Today's Date:_____

Name: _____
Date of Birth: _____ Age: _____ Gender: _____
Mailing Address: _____
City or Town: _____ Prov: _____ Postal Code: _____
Phone Number: _____ Alt. Phone No: _____
I send out e-mail newsletters about once a month. Would you like to join the list? ◯ Yes
(You can unsubscribe at any time.)
E-mail Address: _____

Dr. Name: _____ Clinic: _____
Date of last visit: _____
Are you presently taking any medications: ◯ Yes ◯ No
If yes, reason for taking? _____

Have you ever received any type of mental health services (psychotherapy, psychiatric services, etc)?
◯ Yes ◯ No If yes, who was your practitioner: _____
Have you ever been prescribed psychiatric medication: ◯Yes ◯ No
If yes, please list and provide dates: _____

Current Occupation: _____ No. of years: _____
If retired, what was your main line of work? _____
Do you enjoy your work? _____

Are you currently experiencing any chronic pain: ◯ Yes ◯ No
If yes, please describe: _____
Do you sleep well? ◯ Yes ◯ No
If no, can you describe your sleeping pattern? _____

Are you currently experiencing anxiety, panic attacks or have phobias? ◯ Yes ◯ No
Overwhelming sadness, grief or depression? ◯ Yes ◯ No
If yes when did it begin? _____

Do you have allergies or sinus conditions? ◯ Yes ◯ No
List: _____

Is your blood pressure: ◯ High ◯ Normal ◯ Low
Does your doctor say you have heart disease? ◯ Yes ◯ No

Are you diabetic? ◯Type I ◯ Type II ◯ Not Diabetic

Are you pregnant? ◯ Yes ◯ No If so what trimester? _____
Do you have any children? ◯ Yes ◯ No
How old are they? _____
Marital status: ◯ Happily Married ◯ Married ◯ Divorced ◯ Widowed ◯ Single

Have you ever had an epileptic episode? ◯ Yes ◯ No
If yes, how long ago? _____

Have you ever had a serious injury, accident or fall? (As in, significant enough that you remember it clearly or it still causes you issues today.) ◯ Yes ◯ No
Details if yes: _____

In the last 6 months have you had a severe blow to the head or neck injury? ◯ Yes ◯ No
In the past year have you had any of the following:
◯ Stroke ◯ Aneurism ◯ Spinal tap or Epidural ◯ Severe blow to the head
If so, how long ago? _____

Do you drink alcohol more than once a week? ◯ Yes ◯ No
If you engage in recreational drugs use, how often do you use?
◯ Never ◯ Infrequently ◯ Monthly ◯ Weekly ◯ Daily

Is there anything about your health or life issues you would like to mention:

_____

_____

_____

Ionic Cleanse:

Do you have a pacemaker or any other electrical implant?	◯Yes	◯No
Are you on medications to prevent rejection of a transplanted organ?	◯Yes	◯No
Do you have any screws, plates or metal implants anywhere in your body?	◯Yes	◯No
Are you on blood pressure medication?	◯Yes	◯No
If so, do you you have symptoms if you miss a dose?	◯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

Consent to receive treatment:

I certify that everything on this form is true and correct to the best of my knowledge. I also understand that the IonCleanse is not a medical device and is not intended to diagnose, treat, cure or prevent any disease or ailment.

By signing this form I consent to receive treatment(s) given to me.
I understand Grace cannot medically diagnose and that these treatments are **NOT a replacement for medical attention.**

Signature: _____ Date: _____