Health Naturally, LLC

Foot Detoxification Bath & Release for Service

First Name________________________ Last Name______________________________

Address_____________________________City_______________ST_____Zip__________

Home Phone_________________________ Work Phone____________________________

Cell Phone___________________________ Email_________________________________

Age_______ Sex M F Height_______ Weight__________ Eye color_____________

Birth Date__________________________ Marital Status M S W D Children No.__________

Release of liability, Waiver of Claims, Assumption of Risks & Indemnity Agreement

Current condition;
Platinum Detox International, the manufacturer of the Platinum Energy Systems™ Foot Spa, which Health Naturally, LLC provides as a service, does not recommend Foot Spa sessions for the following conditions.

Pregnancy/Breast Feeding Epilepsy Organ Transplant recipients
Open cuts on Feet Pacemaker recipients Psychotic episodes/seizures
Children under the age of 5

Waiver;
I waive the right to any claims that I may have now or in the future in regards to the Foot Spa session I am about to experience. I hereby acknowledge that I have read the above waiver & agree and accept Full responsibility for any possible risks endured during this & future Foot Spa sessions.
I am aware that by signing this document, I am waiving the right to any liability claim against the practitioner for any liability for personal injury.

Date______________________________ *(Please also fill out side 2)*↓

Name (Print)__________________________Signature_____________________________

Personal Health History

- Do you have a heart pace maker? Yes No
- Are you Pregnant /Brest feeding? Yes No
- Have you had organ transplants? Yes No
- Do you have Epilepsy? Yes No
- Do you take Anti-depressant medications? Yes No
- Do you have open wounds on your Feet? Yes No

Occupation_________________________________ How long?_________________

Are you allergic to any Food/Medication?____

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What conditions are you presently under a Physicians care for?________________________

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Please list all medications you are currently taking?_______________________________

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In case of Emergency contact person:

Name___________________________ Relationship___________________________

Phone__________________________ Other________________________________