THE PIPER CENTER *for Internal Wellness*
IonCleanse/Jing Orb Intake Form

*Please help us provide you with the most effective service by completing the following questions. All information is kept **confidential.***

Personal Data: (please print)

First Name _____ Last Name _____

Address _____ City_____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Occupation _____ Date of Birth _____

Male_____ Female _____ Current Type of Exercise Routine_____

Reason for Visit, Motivations, Expectations _____

_____

Emergency Contact_____ Number_____

What do you want to be treated for: _____

Indicate your general feeling of well being at this time from 1 to 10. 1 indicates worse possible feeling, 10 indicating the best you could possibly feel. Please circle.

1 2 3 4 5 6 7 8 9 10

Past Medical History: _____
Past Surgical History:_____
Allergies: ☐Yes ☐No Meds. Penicillin, Sulfur, NSAIDS, Other _____
Supplements: _____
Muscle Testing: _____
Polarity Option: ☐All Positive ☐All Negative ☐70+/30- ☐15+/10-/5+ ☐10-/15+/5-

Other Info:
_____
_____
_____

CONTRAINDICATIONS

☐Yes ☐No	Person with a pace maker or any other battery operated or electrical implant
☐Yes ☐No	No response to muscle test, or who test weak to both polarities, with their feet in the water and with the unit turn on.
☐Yes ☐No	Are you a person on heartbeat regulating medication
☐Yes ☐No	Organ transplant recipients
☐Yes ☐No	Are you on medication, the absence of which would mentally or physically incapacitate them, such as psychotic episodes, seizures, etc
☐Yes ☐No	Pregnant or lactating

I have read and agree to the polices of THE PIPER CENTER *for Internal Wellness*

- Please be on time. If you are late, a shortened session will be charged at the full rate.
- We request payment in full at the time of your visit. We accept cash, Visa, MasterCard and personal checks.
- A referral from your primary health care provider or our supervising physician is required if you a condition or are following a prescribed treatment.
- We require 24 hours notice for all cancellations or postponements: otherwise you will be charged the full session. As a courtesy, we give clients a telephone reminder a day or two before an appointment.
- All series must be used within 1 year. No refunds are given after the 1 year expiration date.
- I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder. The therapist does not prescribe medical treatment or pharmaceuticals. It has been explained to me that colon therapy is not a cure or substitute for a medical examination, treatment or diagnosis. It is recommended that I see physician for any ailments that I might have. All information that I provided is correct to the best of my knowledge. If any health issues arise, I agree to inform my therapist.

Thank you for choosing THE PIPER CENTER *for Internal Wellness* for your alternative medical care. We look forward to working with you in your journey toward Health Inside and Out.

Client Signature _____Date:_____