

PERSONAL HISTORY FORM

Name: _____
Telephone: (h) _____ (w) _____ (cell) _____
E-Mail Address: _____

Can we leave a message to remind you of your appointment? Yes _____ No _____

Address:
Street/Suite/Apt: _____ City _____ State _____ Zip _____

Occupation: _____ How did you hear about us? _____

Height : _____ Weight: _____ Birth Date: _____ Age: _____ Sex: _____

Why have you chosen to have a colonic/Colon Hydrotherapy session(s)? Please check all that apply:

- Doctor suggested or prescribed _____
Do you have a prescription with you? Yes _____ No _____
- Ninth Amendment Right to Self-Treat _____
- Other. Please explain _____

Who is your primary care physician? _____

When was your last physical examination? _____

Results: _____

CONTRAINDICATIONS: Have you ever been diagnosed with any of the following:

- | | |
|-------------------------------------|-------------------------------------|
| ___ Abdominal Hernia | ___ Colitis |
| ___ Abdominal Distention | ___ Dialysis |
| ___ Acute Liver Failure (cirrhosis) | ___ Diverticulosis/Diverticulitis |
| ___ Anemia, Severe | ___ Fissures & Fistulas |
| ___ Aneurysm-All Types | ___ Hemorrhaging (gastrointestinal) |
| ___ Carcinoma of the Colon | ___ Hemorrhoids PROPLAPSED |
| ___ Cardiac Condition | ___ Intestinal Perforations |
| ___ Crohn's Disease | ___ Lupus |
| | ___ Rectal/Colon Surgery |

Are you pregnant? _____ If yes, what trimester? _____

Are you taking oral steroidal anti-inflammatory medications, i.e. prednisone? _____
If yes, for how long? _____

Have you had a surgical procedure within the last year? Yes ___ No ___

If yes, please indicate the date and nature if the surgery: _____

How often do you have bowel movements? _____

Is elimination complete? _____

Any other symptoms? _____

Please check all the following symptoms that currently apply to you.

Acne___	Chronic Cough___	HIV Positive ___
Allergies___	Constipation___	Menstruating___
Belching/Gas___	Depression___	Migraines___
Bladder Infections___	Diarrhea___	Nausea___
Blood in Urine___	Difficult Digestion___	Pain Over Abdomen___
Blood In Stool___	Difficulty Breathing___	Parasites___
BM Painful/Difficult___	Excessive Hunger___	Rectal Bleeding___
Bruises Easily___	Fainting ___	Skin Eruptions___
Burning/Itching Anus___	Fatigue___	
Chest Pain___	Hepatitis A, B, or C___	

How many hours of sleep do you get nightly? _____

Are you on a special Diet? i.e. Vegan, vegetarian, etc. Yes ___ No ___.

If Yes, explain _____

Do you drink alcohol? ___ Yes ___ No. If yes how many a day? _____

Do you drink coffee, tea or soda? ___ Yes ___ No. If yes how many a day? _____

Do you smoke? ___ Yes ___ No. If yes how many a day? _____

Do you take any daily supplements (vitamins, minerals, herbs, etc.)? ___ Yes ___ No

If yes, please indicate what you take: _____

Do you take daily medications? ___ Yes ___ No

If yes, please indicate your prescription and the condition for which you take it.

Have you had professional colon hydrotherapy before? ___Yes ___No

Where and when: _____

Open or closed system: _____

What is your primary reason for this service? _____

I have not been diagnosed with any contraindications for colon irrigation. I am aware that Colon Hydro-therapists are not physicians and therefore do not insert, diagnose or prescribe. I am aware that adverse events such as perforation, injury and illness have been alleged and claimed with the use of colon irrigation and enema devices. I am responsible for my own self-insertion. If I experience resistance during insertion, I will immediately stop and notify the therapist. If during the session I experience discomfort or pain, I am responsible for immediately stopping my session and notifying the therapist. This facility does not claim to cure or treat any condition or disease.

This information may be shared with our medical consultant, Dr. Roger Janho, for further review.

Client's Signature: _____*

Date: _____

(Clients under the age of 17, the parent or legal guardian's signature is required)