Gentle Waters LLC
Colon Hydrotherapy

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Health History

Name: _____ Age: _____

Address: _____ Phone: _____

City: _____ State ____ Zip Code: _____ Cell: _____

Emergency Contact: _____ Phone: _____

OVERVIEW

How did you hear of Gentle Waters? _____

Reason for visit: _____ Physician's Order _____ 9th Amendment Right to Self-Prescribe

Have you discussed Colon Hydrotherapy with your physician? _____

If yes, any special instructions? _____

What therapies are you here for/interested in: ___Colon Hydrotherapy ___Infrared Sauna

Hydrotherapy Clients only:

How often do you have a bowel movement? _____

Are your bowel movements: (Check all that apply)

☐ Spontaneous	☐ Laxative use	☐ Enemas
☐ Only after eating	☐ Herbal laxative	☐ Rectal Bleeding
☐ Strained	☐ Stool softener use	☐ Hemorrhoids
☐ Effortless	☐ Suppositories	

What do you hope to achieve from your appointment today? _____

_____

MEDICAL

Are you currently under a physician's care? _____ Treating MD _____

If yes, please explain: _____

Surgeries _____ Date _____

_____ _____

_____ _____

Medications _____ Start Date _____

_____ _____

_____ _____

Health History Continue

Supplements _____ Start Date _____

_____ _____

_____ _____

Food Allergies: _____

Medication Allergies: _____

Are you Pregnant or could be Pregnant? _____

Please indicate usage and amount.

Coffee use _____ Alcohol use _____ Carbonated Drinks _____

Tea use _____ Tobacco use _____ Daily Water Intake _____

Please check any current or past health conditions. C for current, P for past.

- ☐ Abdominal Hernia
- ☐ Abdominal Surgery
- ☐ Abnormal Distension
- ☐ Addiction
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bad Breath
- ☐ Barium Enema
- ☐ Blood Clots
- ☐ Blood in Stool
- ☐ Bronchitis
- ☐ Burning Stomach
- ☐ Burning/itching anus
- ☐ Cancer, any kind
- ☐ Cardiac (Heart) Condition
- ☐ Chronic Fatigue
- ☐ Circulatory Problems
- ☐ Coated/Dry Tongue
- ☐ Colitis
- ☐ Colonoscopy
- ☐ Constipation
- ☐ Crohns Disease
- ☐ Depression/Bipolar
- ☐ Diabetes
- ☐ Dialysis Patient
- ☐ Diarrhea
- ☐ Difficult/Painful Bowel Movements
- ☐ Difficulty Sleeping
- ☐ Digestive Problems
- ☐ Diverticulitis
- ☐ Epilepsy
- ☐ Extreme Stress
- ☐ Fissures/Fistula
- ☐ Frequent Burping
- ☐ Gas/Foul Odor
- ☐ Greasy Food Reactions
- ☐ Hemorrhaging (bleeding)
- ☐ Hemorrhoidectomy
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Indigestion
- ☐ Intestinal Perforations
- ☐ Irritability
- ☐ Laxative Use
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Nausea
- ☐ Parasitic Infection
- ☐ Recent Accident
- ☐ Rectal/Colon Surgery
- ☐ Renal (Kidney) Problems
- ☐ Respiratory/Sinus Problems
- ☐ Skin Problems
- ☐ Spinal Injuries
- ☐ Stool/Foul Odor
- ☐ Swollen Ankles
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vomiting

I certify that all information is correct. I am here of my own free will for the sole purpose of receiving offered therapies. I understand that colon hydrotherapists are not physicians and cannot diagnosis or make claims to treat or cure disease. I understand that if I have or have been diagnosed with any contraindication for colon hydrotherapy including abdominal hernia, abdominal surgery within 6 months, abnormal abdominal distention, acute liver failure or cirrhosis, anal fissures or fistulas, anemia, aneurysm, colon cancer and/or surgery, Crohns Disease, intestinal perforations, pregnancy, rectal bleeding, severe cardiac condition, ulcerative colitis, uncontrolled high blood pressure, or any other health concern the therapist deems as a contraindication, I can be denied therapies.

Signature _____ Date _____

You will be charged for your full appointment if not cancelled or changed within 24 hour notice.