Holistic Questionnaire

Please Answer All Questions

NAME _____ PHONE _____

E-MAIL _____

What is your preferred form of contact for reminders and messages? PHONE ☐ EMAIL ☐

Date of Birth _____ This Center wants to celebrate YOU! 10% OFF SERVICES during the WEEK of your BIRTHDAY!!!

Marital Status ____ Sex____Number of children you have?____ Women only: Pregnant?_____Which Trimester?_____

Are you under a Doctor's care? _____ If so, please explain _____

List any surgeries you have had in the last six months _____

List all medications & supplements you now take regularly (including over the counter) _____

Please give details of any allergies you may have: _____

How did you hear about us? Yelp ☐ Facebook ☐ Twitter ☐ Google ☐ Instagram☐ Friend☐ _____

Please read below carefully before signing:

I have read the notice at the top and declare that I am not an agent.

Please initial: _____

SUPPLEMENTS: I take full responsibility for any products I purchase.

Please initial: _____

California only, I have read, signed and received a copy of the State of California Guidelines Notice SB-577.

Please initial: _____

CANCELLATION POLICY: A FULL PAYMENT IS DUE FOR ANY CANCELLATION WITHIN 24-HOUR.

Please initial: _____

ALL SPECIAL PACKETS/DISCOUNTS/SERIES ARE NON-REFUNDABLE.

Please initial: _____

"The purpose of this center and all the staff is to provide services, products and offer information to clients. Our services, products and information are for vocational and advocational self-improvement. We do not intend to treat, diagnose, prescribe or cure. All procedures are directed towards the establishment of this goal."

Because you must be aware of any existing physical conditions that I may have, I have honestly answered all above questions and am not intentionally withholding information about my health. I will inform "the center" of any changes in my physical health. I am agreeing to the office policies and procedures of This Center .

Signature: _____ Date: _____

Colon Hydrotherapy

Please Answer All Questions

You **MUST** check **YES** or **NO** for each of the following and indicate any **ACTIVE (A)** CONTRAINDICTIONS:

	Y	N	A		Y	N	A		Y	N	A		Y	N	A
1st Trimester of Pregnancy				Cancer				Fissures/Fistulas				Severe Cardiac Disease			
Abdominal Hernia				Chemo/radiation treatment				GI Hemorrhage/Perforation				Severe Diverticulitis			
Advanced Pregnancy				Cirrhosis				Renal Insufficiency				Severe Hemorrhoids			
AIDS/HIV				Colon Surgeries				Severe Anemia				Ulcerated Colitis			
Aneurysm				Crohn's Disease											

PLEASE EXPLAIN & INDICATE DATES OF DIAGNOSIS_____

THE FOLLOWING IS **OPTIONAL**, BUT IT HELPS THE THERAPIST TO PREPARE A BETTER SESSION FOR YOU:
PLEASE INITIAL SHOULD YOU CHOOSE NOT TO ANSWER _____
1.OCCASIONAL/MILD SYMPTOM **2**. FREQUENT/MODERATE SYMPTOM **3**.SEVERE/CONSTANT SYMPTOM OR '**NO**' IF NOT APPLICABLE

HEALTH HISTORY	NO	#	HEALTH HISTORY	NO	#	HEALTH HISTORY	NO	#
Allergies			Diabetes			Lung disorders		
Allergies drug reaction			Digestive Problems			Lupus		
Anemia			Diverticulosis			Painful Menstruation		
Anorexia/ Bulimia			Dizziness			Date of last menstrual cycle		
Arthritis			Double/blurred vision			Vaginal discharge		
Asthma			Earache			Breast Pain		
Back problems/pain			Edema/ swelling			Muscle / Joint pain		
Bad breath			Excess Gas			Muscle Stiffness		
Bitter metallic taste			Excessive hair loss			Neuropathy		
Bladder disorders			Fatigue			Organ Transplant		
Bladder infection			Frequent colds			Pacemaker		
Bronchitis			Headaches			Poor appetite		
Burping			Heart-burn/ acid reflux			Prostate problem		
Chronic cough			HEP-C / HIV / Aids			Seizures		
Chronic fatigue			Hemorrhoids			Sinus Problems		
Colitis			High/low blood pressure			Skin disease		
Cold Sores			Insomnia			Uterus disorder		
Constipation			Irritable bowel (IBS)			Uterus/ Ovary problems		
Depression			Liver disorders			Organ Transplant		

If you answered **YES** to any, please explain and indicate how long you have had this situation: _____

_____

THE FOLLOWING IS **OPTIONAL,** BUT HELPFUL:

Yes	No		If Yes Please Explain
		Do you drink alcohol?	
		Do you drink coffee?	
		Do you smoke?	
		Have you ever used drugs recreationally?	
		Are you currently taking prescription drugs?	
		Do you have irregular sleeping habits/insomnia?	
		Do you have any reaction if meals are delayed?	
		Do you have indigestion?	

CONTINUED ON BACK

WHAT ARE YOU EXPECTING TO RECEIVE FROM This CENTER?

Is there anything specific you would like to work on during the session? What are your long-range goals?

_____

Are you allergic to COCONUT OIL? YES NO

I have been informed & agree to self-insertion & self- retraction of the speculum. PLEASE INTITIAL _____

Have you ever had a colonic before? If yes, when was your last session: _____

How many bowel movements per day do you have? _____ Do you strain to have a bowel movement? _____

Do you use a stool softener or laxative? _____ Herbal laxative? _____ Suppository? _____

Do you have hemorrhoids or other rectal problems? _____

Have you ever had bleeding from colitis or any bodily orifice? _____

Have you ever had a barium enema? If so, when? _____

Have you ever had a colonoscopy? If so, when? _____

How much water do you drink per day? _____

Are you always hungry/never hungry or eat when nervous? _____

Do you have reactions when meals are delayed? _____

Do you crave any foods? *If YES give details:* _____

Please read all above carefully before signing:

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Because you must be aware of any existing physical conditions that I may have, I have honestly answered all above questions and am not intentionally withholding information about my health. I will inform this center of any changes in my physical health. I am agreeing to the office policies and procedures of this Center.

Contraindications

It's essential to be aware of specific health conditions that may make colon hydrotherapy unsafe. It's crucial for clients to disclose any known medical conditions before undergoing colonic hydrotherapy to ensure their safety and well-being. If any of the following apply to you, we would require a doctor's note to schedule a service:

Contraindications
Abdominal Hernia
Diverticulitis
Abdominal Surgery
Fissures/Fistulas
Hemorrhoids
Acute Liver Failure
Hemorrhoidectomy
Anemia
Intestinal Perforation(s)
Aneurysm (any type)
Lupus
Cancer of the Colon
Current Knowledge/Possibility of Pregnancy
Cardiac Condition (i.e., uncontrolled hypertension, congestive heart failure)
Crohn's Disease

Colitis
Rectal/Colon Surgery
Renal Insufficiencies
Hemorrhaging
Dialysis Patient
Diverticulosis
Rectal Bleeding
If any of the above apply to you, you will not be able to schedule a service without a doctor's note. FDA-registered closed system (Type II medical device)

Signature: _____ Date: _____