Case History Application

NAME _____ Email _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
DATE OF BIRTH _____
HOME#( ) _____ WORK#( ) _____ CELL#( ) _____
Referred By: _____ WT _____ HT _____ BLOOD TYPE _____

PLEASE PUT AN "X" BESIDE ANYTHING THAT IS CURRENTLY A HEALTH CHALLENGE FOR YOU. PLACE A "P" FOR PAST PROBLEMS.

_____AIDS/HIV
_____ALLERGIES
_____ANEMIA
_____ANTIBIOTIC USE
_____ARTHRITIS
_____BACKACHES
_____BELCHING
_____BIRTH CONTROL PILLS
_____CANCER
_____CANDIDA
_____COLITIS
_____CONSTIPATION
_____CYSTS/TUMORS
_____DIABETES
_____DIARRHEA*
_____DIFFICULT URINATION
_____DIVERTICULITIS
_____DIVERTICULOSIS
_____DIZZINESS
_____EPILEPSY
_____FATIGUE
_____FIBROMYALGIA
_____FLATULENCE/GAS
_____FREQUENT URINATION
_____GALL BLADDER
_____HEADACHES
_____HEARING PROBLEM
_____HEART PROBLEMS*
_____HEMORRHOIDS
_____HEPATITIS
_____HERPES
_____HIGH BLOOD PRESSURE*
_____HYPOGLYCEMIA
_____IBS
_____INDIGESTION/REFLUX
_____INSOMNIA
_____IRRITABILITY
_____KIDNEY PROBLEMS
_____LIVER
_____LOW BLOOD PRESSURE*
_____MENOPAUSE
_____PARASITES
_____PMS
_____PROSTATE PROBLEMS
_____SINUS PROBLEMS
_____SWOLLEN GLANDS
_____ULCERS
_____VISION PROBLEM
_____WATER RETENTION
_____YEAST INFECTIONS

ARE YOU PREGNANT? _____ HOW DO YOU SLEEP AT NIGHT? _____
WHAT TYPE WORK DO YOU DO? _____

The following is a list of contraindications for using colon hydrotherapy. If you have ever been diagnosed with ANY of these conditions a doctors prescription/order will be required to use this procedure.

Uncontrolled Hypertension
GI Hemorrhage
Cirrhosis of the Liver
Fistulas
Recent Colon Surgery (less than 3 mo.)
Lupus
Congestive Heart Failure
Severe Hemorrhoids
Carcinoma of the Colon
Abdominal Hernia
Pregnancy (1st & 3rd trimesters)
Intestinal Perforations
Severe Anemia
Renal insufficiency
Fissures
Chron's Disease
Ulcerative Colitis

DO YOU HAVE AN ALLERGY TO LATEX OR PETROLEUM PRODUCTS? _____

CURRENT HEALTH DIFFICULTIES OR SYMPTOMS: _____

PHYSICIAN'S OR CHIROPRATOR'S DIAGNOSIS OF CURRENT OR PAST DISEASE OR ILLNESS: _____

HISTORY OF SURGERY (Indicate your age at the time of each surgery): _____

SIGNIFICANT PHYSICAL AND/OR EMOTIONAL TRAUMA OR INJURY: _____

DO YOU TAKE?
_____ MULTI-VITAMINS - BRAND: _____
_____ DIGESTIVE ENZYMES - BRAND: _____
_____ PROBIOTICS - BRAND: _____

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MEDICATIONS YOU ARE CURRENTLY TAKING	WHAT DO YOU TAKE THIS FOR?	DATE YOU STARTED

SUPPLEMENTS YOU ARE CURRENTLY TAKING	WHAT DO YOU TAKE THIS FOR?	DATE YOU STARTED

DO YOU DRINK, EAT OR USE:

_____ALCOHOL
_____COFFEE _____# CUPS
_____SALT
_____SODA POP _____DIET
_____SUGAR
_____TEA ____HERBAL
_____TOBACCO
_____VEGETARIAN DIET
_____WATER _____OZ/DAY

FREQUENCY OF BOWEL MOVEMENTS (BM)

_____LESS THAN ONCE A WEEK
_____ONCE A WEEK
_____ABOUT EVERY ___ DAYS
_____EVERY OTHER DAY
_____DAILY
_____TWICE DAILY
_____AFTER EACH MEAL
_____SPONTANEOUS
_____ONLY AFTER EATING
_____EFFORTLESS
_____OFTEN REQUIRES STRAINING
_____PAINFUL
_____BLOOD IN STOOL
_____DOES NOT FEEL COMPLETE

LENGTH & DIAMETER OF BM:_____

DO YOU USE LAXATIVES OR ENEMAS	WHAT TYPE OR BRAND?	HOW OFTEN?

I fully understand that this office is not a medical establishment and I am not here for a medical diagnosis. I understand that the practitioner I am about to see is a specialist in alternative therapies and practices, not a medical doctor. I hereby give all liberty and permission to this office and any of its staff to make all suggestions to my illness or described symptoms. I understand this office may utilize kinesiology, muscle testing, iridology, lab testing or other methods for evaluating. One or more alternative therapies may be used or suggested in order for me to reach vibrant health. All suggestions are in the best interest of my health. If I have any questions, I will ask them during my consultation. I agree to and will inform my practitioner prior to my session of any changes in my medications and health issues.

I understand that this office requires a 24 hour minimum advance notice of cancellation of a scheduled appointment and that cancellations made less than 24 hours before the appointment will be charged the regular fee. Due to the scheduling of other clients, this office cannot guarantee appointments for late arrivals, nor can they extend the allotted appointment time to accommodate a late arrival. I understand that my appointment will be automatically canceled 20 minutes after my scheduled appointment time and my credit card on file will be charged the regular fee.

I am not on this visit or any subsequent visit an agent for the federal, state, medical or local agencies or on a mission of entrapment or investigation.

Using, accepting or utilizing any of the nutritional information, suggestions or offered remedies or therapies is my own personal choice, for which I alone take full responsibility (which is my constitutional right).

SIGNATURE:_____DATE _____

I _____ have read the above contraindications for colon hydrotherapy and by my signature I testify I DO NOT HAVE ANY of the above conditions. I am also aware that the use of colon hydrotherapy is by own personal choice and that the therapist is not a medical doctor nor portrays themselves as such. Colon hydrotherapy has not been clinically tested to provide ANY medical benefits. This facility does not claim that the use of colon hydrotherapy will cure or treat any condition or disease. This procedure is used solely for the purpose of evacuating the lower bowel.

SIGNATURE:_____DATE _____

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