Personal History Form

Name ____ **Date** ______________________

Address ____

City ____**State** ___________________ **Zip** ___________

Home Phone ________________________________**Work Phone** ________________________________

Birth Date _______________________ **Age** ______________________ **Gender**______________________

Email ____

Please check all of the following symptoms, which you now have or have had previously. Be as thorough as possible! Your health history is strictly confidential.

General Symptoms
Headache
Fever
Chills
Sweats
Fainting
Allergy
Dizziness
Convulsions
Loss of sleep
Fatigue
Nervousness / depression
Loss of weight
Overweight
Numbness in _____________

Eyes, Ears, Nose, Throat
Failing vision
Near sightedness
Far sightedness
Crossed eyes
Eye pain
Deafness
Earache
Ear noises
Ear discharge
Nose bleeds
Nasal obstruction
Nasal drainage
Sore throat
Swollen tonsils
Enlarged lymph glands
Enlarged thyroid
Hoarseness
Colds
Sinus infection

Skin
Skin eruptions
Itching
Bruises easily
Dryness
Boils
Varicose veins
Sensitive skin
Hives or allergies

Respiratory
Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficult breathing

Cardio-vascular
Rapid heart beat
Slow beating heart
High blood pressure
Low blood pressure
Pain over heart
Heart attack
Swelling of ankles
Poor circulation

Muscle, Bone, & Joint
Stiff neck
Backache
Swollen joints
Tremors
Painful tailbone
Foot or ankle trouble
Pain in: shoulders, hips, legs, knees, feet, other?
Hernia, spinal curvature
Faulty posture

Genito-urinary
Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney trouble
Inability to control urine
Prostate trouble

Gastro-intestinal
Poor appetite
Excessive hunger
Difficult digestion
Belching or gas
Distention of abdomen
Nausea
Vomiting
Vomiting of blood
Pain over stomach
Pain over lower abdomen
Constipation
Diarrhea
Colon trouble
Bloody stools
Intestinal parasites
Liver trouble
Gall bladder trouble
Jaundice

For Women Only
Painful menstrual periods
Excessive menstrual flow
Hot flashes
Irregular cycle
Cramps or backache
Miscarriage
Vaginal discharge
Lumps in breast

Check any of the following conditions you now have:

Dental cavities	Diabetes	Goiter	Multiple sclerosis	Small pox
Gum trouble	Diphtheria	Gout	Nervous breakdown	Tuberculosis
Appendicitis	Eczema	Heart problems	Pneumonia	Ulcers
Arteriosclerosis	Emphysema	Malaria	Polio	Venereal infection
Arthritis	Epilepsy	Measles	Rheumatic fever	Whooping cough
Cancer	Fever blisters	Mental disorders	Mumps	Scarlet fever
Chicken pox	Colitis	Flu	Stroke	Other____________

Have you ever: **Please describe the what and when of any situation below:**

Had any unusual accidents or falls? ____
____

Had any bone fractures? ____
____

Been knocked unconscious? ____
____

Had any surgical operations? ____

Habits:

Sleep – Hours daily? ___________________________ Is it enough? ________________________________
Exercise – Daily? ______________________________ Is it enough? ________________________________
Fresh Air – Daily? _____________________________ Is it enough? ________________________________
Water – Daily? ________________________________ Is it enough? ________________________________
Food – Too much or little? ______________________ Is it enough? ________________________________

Positive Attitude – Consistent? ____
Emotions – Do you feel they are in balance? ____

Do you use any of the following on a daily basis?

Alcohol Coffee Tea Tobacco
Supplements:
Vitamins:
Minerals:
Herbs:

Most recent medical service / hospitalization? – For what, where, and when _____________________________
____
____

Your #1 health goal or concern at this time? ____
____
____

____
Client

Informed Consent

This health center _____________________________________ informs you of the following things:

1. We do not diagnose.

2. We make no attempt to cure any condition.

3. We make no claim to imply any claim that suggestions are given to cure any condition.

4. We do not claim that any supplemental material that we speak about will cure any condition or that its purpose is to treat any condition.

5. We do not prescribe or treat disease, however we do attempt to educate you on food and conscious diet choices, exercise and lifestyle choices if they are not contradictory to the recommendations of your primary health care provider or your physician.

I, the undersigned client of this health center _______________________________________, understand the above statements and understand that diet, nutrition, and lifestyle consultations are considered to be inexact sciences and that the results obtained are note always consistent or predictable.

Whether or not I participate in the procedures offered by this center is my decision based on my God-given inalienable rights and my constitutionally guaranteed rights secured by the U.S. Bill of Rights. It is my Creator-endowed Inalienable Right to ask for assistance of my own choosing and I accept full responsibility for any outcome. I understand that there is no guarantee of any result and the opposite of the desired result may appear. Whether or not I ask for assistance is my decision. All decisions relative to my health must be made by me.

I understand that all the practitioners here are not medical doctors and are not attempting to portray or conduct the activities of a medical doctor, and I waive any liability on behalf of the practitioner.

Name ____ Date ___________________

Address ____

City _____________________________________ State ______________________ Zip ____________________

Signature ____ Phone ______________________

Medical Indications for Use of Colon Hydrotherapy

Check all that apply:

_______For endoscopic or x-ray / radiological examination

_______Constipation or fecal impaction

_______Other: Describe____

Contraindications for Use of Colon Hydrotherapy

Have you had within the last 6 months:

	YES	NO
• Congestive heart failure	____	____
• Intestinal perforation	____	____
• Carcinoma of the rectum	____	____
• Fissures or fistula	____	____
• Severe hemorrhoids	____	____
• Abdominal hernia	____	____
• Renal insufficiency	____	____
• Recent colon or rectal surgery	____	____
• Abdominal surgery	____	____
• First and last trimester of pregnancy	____	____
• Cirrhosis	____	____

Client Signature ____ Date _____________________

Print Name ____

Client Address ____

City ________________________________ State _____________________________ Zip ___________________

Client is cleared for colon hydrotherapy as needed for a 6-month period.

____ Date ___________________

Prescribing Doctor’s Signature

Lic#____