



# PERSONAL HISTORY FORM

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_ Occupation \_\_\_\_\_

How did you hear about us? Google/ Yahoo/ Bing/ Ask /Facebook/ Friend/Referral: \_\_\_\_\_  
(circle one)

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 Prescription \_\_\_\_ Ninth Amendment Right to Self Treat \_\_\_\_ Other \_\_\_\_\_

**\*Contraindications (a colonic can not be administered if anything in this box is checked): Have you been diagnosed with the following?**

<input type="checkbox"/> Abdominal Hernia	<input type="checkbox"/> Colitis
<input type="checkbox"/> Abdominal Surgery	<input type="checkbox"/> Dialysis
<input type="checkbox"/> Abnormal Distention	<input type="checkbox"/> Diverticulosis/Diverticulitis
<input type="checkbox"/> Acute Liver Failure	<input type="checkbox"/> Fissures & Fistulas
<input type="checkbox"/> Anemia (severe)	<input type="checkbox"/> Hemorrhaging
<input type="checkbox"/> Aneurysm – All Types	<input type="checkbox"/> Hemorrhoidectomy
<input type="checkbox"/> Carcinoma of the Colon	<input type="checkbox"/> Intestinal Perforations
<input type="checkbox"/> Cardiac Condition	<input type="checkbox"/> Lupus
<input type="checkbox"/> Crohn’s Disease	<input type="checkbox"/> Pregnant (due date _____)
<input type="checkbox"/> Are you currently taking any medications that weaken the intestinal walls?	<input type="checkbox"/> Rectal/Colon Surgery
	<input type="checkbox"/> Renal Insufficiencies

- BM Painful/Difficult
- Bladder Infection
- Blood in Stool
- Burning/Itching Anus
- Heart Trouble
- High Blood Pressure
- Hemorrhoids
- Rectal Bleeding
- Recent Barium Enema
- Recent Colonoscopy
- Use Laxatives
- How often do you have bowel movements?** \_\_\_\_\_

Any other symptoms? \_\_\_\_\_

HIV Positive, Hepatitis A, B or C, etc.

Are you under a doctor’s care? \_\_\_\_\_

Have you had a surgical procedure within the last year? \_\_\_\_\_

I have not been diagnosed with any contraindications for colon irrigation (see above\*). I am aware that Colon Hydrotherapists are not physicians and therefore do not insert, diagnose or prescribe. I am aware 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 the 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.

Client Signature: \_\_\_\_\_

(If client is under the age 17, signature of the parent or guardian is required)

## GENERAL HEALTH INFORMATION

Please **circle** all of the following symptoms that currently apply to you and on a scale of 1-10, 10 being the worst, please **rate** the severity of your symptoms.

Acne	___	___	Difficult Breathing	___	___	Jaundice	___	___
Allergies	___	___	Difficult Digestion	___	___	Kidney Problems	___	___
Belching/Gas	___	___	Dry Skin	___	___	Liver Trouble	___	___
Blood in Urine	___	___	Excessive Hunger	___	___	Nausea	___	___
Boils	___	___	Fainting	___	___	Nervousness	___	___
Bruises Easily	___	___	Fatigue	___	___	Overweight	___	___
Chest Pain	___	___	Fever	___	___	Pain over Abdomen	___	___
Chills	___	___	Frequent Urination	___	___	Painful Urination	___	___
Chronic Cough	___	___	Gall Bladder Trouble	___	___	Parasites	___	___
Constipation	___	___	Headaches	___	___	Poor Appetite	___	___
Depression	___	___	Insomnia	___	___	Skin Eruptions	___	___
Diarrhea	___	___	Itching	___	___	Sweats	___	___

## HABITS

How many hours of sleep do you get nightly? \_\_\_\_\_

How often do you exercise? \_\_\_\_\_

How much water do you drink daily? \_\_\_\_\_

What types of foods do you eat? \_\_\_\_\_

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

Alcohol \_\_\_\_\_

Coffee/Tea \_\_\_\_\_

Sodas \_\_\_\_\_

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

If yes, please indicate what you take. \_\_\_\_\_

Do you take any medications daily? 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 \_\_\_\_\_

What is your primary reason for this service?

\_\_\_\_\_

What is your #1 health goal or concern at this time?

\_\_\_\_\_



## **PREMIER HEALTH AND WELLNESS**

### **Informed Consent**

I, the undersigned, am in full agreement that colonic irrigation is not a proven method, cure or treatment of disease or condition, nor has it been portrayed as such. Colon irrigation in this facility is a self-administered procedure where I, as the user of the device, am solely responsible for my own actions and release liability regarding my health issues.

The device being utilized in this facility is a FDA Registered Class II gravity device that can be used prior to endoscopic procedures.

I understand I will self insert my own speculum and will be in full control of the procedure. I am aware that now all states have laws governing the use of colon irrigation/enema devices. The facility I have chosen to visit is aware of the laws governing the facility at the time I sign this waiver of consent and that at anytime those laws can change and neither I, my family, nor my representative(s) will hold the equipment manufacturer, facility or their employees responsible for my personal choice to receive colon irrigation at this facility nor hold them liable for any changes or variations of the laws after the time of my dated signature below. All results of my session(s) are contributive to research and the utilization in future programs of Self Health Aid, while preserving my privacy, and waive any liability on behalf of the technician serving me.

---

Client Signature

---

Date

If you are currently taking any medication for any condition, prescription or non, you may want to check with your doctor before using colonic irrigation. If you have been diagnosed with any intestinal condition or have taken any medication that can weaken the intestinal walls, you should check with your primary health care provider, before using colonic irrigation. If you are not sure of the side effects of the drugs you are using, you can check on the internet or with your local pharmacist or doctor.

I attest by my signature below that contraindications and adverse events have been fully explained and discussed with me.

---

Client Signature

---

Date

---

Therapist Signature

---

Date