

Health History - Your Health History is Confidential

Name: _____ Birth Date: _____ Today's Date: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Work Phone: (_____) _____ Home Phone: (_____) _____ Cell Phone: (_____) _____
 Occupation: _____ Referred by: _____

Have you recently travelled (Date)? _____ If so, your destination? _____

Please place an X in front of each and every symptom/health condition you have or have previously experienced.

General Symptoms

_____ Headache
 _____ Fever - Currently
 _____ Chills
 _____ Sweats
 _____ Fainting
 _____ Allergies
 _____ Dizziness
 _____ Convulsions
 _____ Loss of Sleep
 _____ Fatigue
 _____ Nervousness/Depression
 _____ Weight Gain/Loss
 _____ Numbness in _____

Skin

_____ Itching
 _____ Bruises Easily
 _____ Dryness
 _____ Varicose veins
 _____ Sensitive skin
 _____ Hives or allergy

Respiratory

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

Cardio-Vascular

_____ Rapid heartbeat
 _____ Slow heartbeat
 _____ High blood pressure
 _____ Low blood pressure
 _____ Pain over heart
 _____ Heart attack
 _____ Swelling ankles
 _____ Poor circulation

Eyes, Ears, Nose & Throat

_____ Failing vision
 _____ Far sightedness
 _____ Near sightedness
 _____ Crossed eyes

_____ Eye pain
 _____ Deafness
 _____ Earache
 _____ Ear noises
 _____ Ear discharge
 _____ Nose bleeds
 _____ Nasal drainage
 _____ Sore throat
 _____ Swollen tonsils
 _____ Enlarged lymph glands
 _____ Enlarged thyroid
 _____ Colds
 _____ Sinus infection
 _____ Hay fever
 _____ Asthma
 _____ Dental Decay
 _____ Gum problems

Genito-urinary

_____ Frequent urination
 _____ Painful urination
 _____ Blood in urine
 _____ Kidney problems
 _____ Inability to control urine
 _____ Urinary Tract Infection (UTI)
 _____ Prostate problems

Muscle, bone & joint

_____ Stiff neck
 _____ Backache
 _____ Swollen joints
 _____ Tremors
 _____ Painful tailbone
 _____ Foot & ankle problems
 _____ Pain in: shoulders, arms,
 elbows, hands, hips, legs,
 knees, feet, or other: _____

Gastro-intestinal

_____ Poor appetite
 _____ Excessive hunger
 _____ Difficult digestion
 _____ Belching or gas
 _____ Distention of abdomen
 _____ Nausea
 _____ Vomiting
 _____ Pain over stomach
 _____ Vagus Nerve/Vasovagal Reflex
 _____ Constipation
 _____ Diarrhea
 _____ Colon problems
 _____ Hemorrhoids or piles
 _____ Rectal bleeding
 _____ Bloody stools
 _____ Intestinal worms/parasites
 _____ Liver problems
 _____ Gall bladder problems
 _____ Jaundice

_____ Hernia
 _____ Spinal curvature
 _____ Faulty posture
 _____ Subluxation
 _____ Pinched nerves

This section for Women Only - If not female please continue to next section

- | | | |
|--|---|--|
| <input type="checkbox"/> Painful menstrual periods | <input type="checkbox"/> Irregular cycle | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Excessive menstrual flow | <input type="checkbox"/> Cramps or backache | <input type="checkbox"/> Lumps in breast |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Menopausal symptoms |

For everyone. Please place an "X" in either the Yes or No space for each of the following questions.

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Are you having any pain or discomfort at this time? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you feel very nervous about having colonic irrigation? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Have you ever experienced colonic irrigation? If yes, when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Have you been a patient in a hospital during the past six weeks? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Have you been under the care of a doctor during the past two years? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Are you taking any prescription medications? If yes, please list current medications: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Are you taking any supplements or herbal medications? If yes, please list current supplements: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Are you on a special diet? If yes, please explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Has your medical doctor ever told you that you have cancer or a tumor? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you have any disease, condition, or health problem not listed?
If yes, please explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you lost or gained more than 10 pounds in the past year? |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you have abdominal bloating/gas? |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you use prescription or over-the-counter laxatives? |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you have rectal bleeding? |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you have perforated or bleeding hemorrhoids? |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you have to strain to have a regular bowel movement? |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Do you have one or more bowel movements per day? |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Have you had a recent colonoscopy or sigmoidoscopy?
If yes, when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. Have you had rectal surgery of any type? (i.e.: partially removal of any portion of the colon) |
| <input type="checkbox"/> | <input type="checkbox"/> | 20. Why have you chosen to have colonic irrigation? _____ |

To the best of my knowledge, all of the preceding answers are correct.

Client signature: _____ Date: _____

Colonics are a perfectly safe and natural procedure however, there are some conditions that may not be benefited by the colonic process. Contraindications to colon hydrotherapy include congestive heart failure, intestinal perforation, carcinoma of the rectum, fissures or fistula, severe hemorrhoids, abdominal hernia, renal insufficiency, recent colon or rectal surgery, cirrhosis of the liver, and first and last trimester of pregnancy.

Curing disease or any other illness is between you and your health care medical professional. Internal Wellness Center does not treat any diseases or illnesses, nor do we make any diagnosis of any illness. Internal Wellness Center is not staffed by medical doctors, and is not attempting to portray itself as a medical professional, nor does it conduct the activities of medical doctors. Colonic hygiene is considered complementary to the recommendations and/or programs of your health care medical professional.



Informed Consent

Neither Internal Wellness Center nor its associates, do any of the following, whether implied or intended:

- We do not diagnose.
 - We make no attempt to cure any condition.
 - We make no claims or imply any claims that suggest a cure for any condition.
 - We do not claim that any supplemental material we speak about will cure any condition, or that its purpose is to treat any condition.
 - We do not prescribe or treat disease; however, we do attempt to educate you in/on dietary recommendations and exercise, if it is not contradictory to the recommendations of your physician(s).
-
- I, the undersigned client, understand the above statements.
 - I, as the undersigned client, understand that diet and nutrition is considered to be an inexact science, and that the results obtained are not always constant or predictable.
 - I also understand that there is no guarantee of any results and that the opposite of my desired results may occur.
 - Whether or not I participate in this procedure and/or program is my decision, based on my constitutional right of the Ninth Amendment. I must make all decisions relative to my wellbeing and health.
 - I further understand that Internal Wellness Center staff are not medical doctors and are not attempting to portray themselves or conduct the activities of medical doctors.
 - I also understand that the medical device used in this procedure is intended for use in colon irrigation.
 - Additionally, I understand the Angel of Water system is registered with the FDA and is intended for colon cleansing to promote general health and wellbeing and when medically indicated, such as preparation for radiological or endoscopic examinations.
 - I understand colonic hygiene is considered complementary to the recommendations and/or programs of my health care/medical professional(s).

If any representations have been made to me concerning this program, or if I have any understanding about this program which representations and/or understandings are contrary to the above statements, I will indicate so at the bottom or reverse side of this form. By signing this form, I state that I am not a D.O.H. agent or Federal Agent or in the services of these agencies, but that I am a client seeking colon hydrotherapy services for my own benefit. I have read this agreement in full and agree to its terms.

Print Name: _____ Street Address _____

City _____ State _____ Zip _____ Email address: _____

Work Phone: (_____) _____ Home Phone: (_____) _____ Cell Phone: (_____) _____

Signature: _____ Date: _____

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Policies

Please read, initial each section where indicated and sign below.

Our Financial Policy

Thank you for choosing Internal Wellness Center as your colon rejuvenation provider. We are committed to your colonic session being successfully completed. Please understand that the prompt payment of your bill is the only way we can continue to provide the best quality and service.

___ We require full payment at the time of service. We accept cash, Master Card, VISA, Discover and American Express. No personal checks please.

Missed and/or Late Appointments

___ Unless **cancelled at least one business day in advance**, we will charge for missed appointments at the full rate of the scheduled appointment. Please help us by keeping your appointment.

___ Late arrival for a scheduled appointment will be accommodated whenever possible. However, due to the scheduling of other clients, late arrivals may need to be rescheduled.

Service Policy

___ Internal Wellness Center reserves the right to refuse to offer our services to individuals with conditions that we feel may be contraindicated to colon hydrotherapy. Clients who we feel are out of our scope of practice may not receive services without the express written original prescription from a medical practitioner.

Signature: _____ Date _____

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