The Nutrition and Wellness Center

Health History

*Name:*_____ *Date:* _____

Address: _____ *Birthdate* _____

City: _____ *State:* _____ *Zip Code:* _____

Mobile Phone: _____ *Occupation:* _____

Email: _____ *Referred by:* _____

YOUR HEALTH HISTORY IS CONFIDENTIAL

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

Curing disease or any other illnesses is between you and your health care/medical professional. The Nutrition and Wellness Center does not treat any diseases or illnesses nor do we make any diagnosis of any illness.

The Nutrition and Wellness Center

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your major health concerns in order of importance:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII				
Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes		No	
Category VIII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes		No	
Category IX				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category X				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3
Category XI				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

The Nutrition and Wellness Center

Contraindications to colon hydrotherapy are as follows: **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. I have not had any of the above in the past six months. I do not exceed the weight of 300 pounds.**

Initial: _____

To the best of my knowledge, I concur that all of the proceeding answers are correct. If I ever have any change in my health or if my prescription medications change, I will inform The Nutrition and Wellness Center. By signing this intake form I acknowledge that I do not have any contraindications to colon hydrotherapy.

Signature: _____ Date: _____

INFORMED CONSENT FORM, COLON HYDROTHERAPY

The Nutrition and Wellness Center do not do any of the following things, either implied or intended:

1. We do not diagnose.
2. We make no attempt to cure any condition.
3. We make no claims or imply any claims that suggestions and/or opinions are given to cure any condition.
4. We do not claim that any supplemental material we may 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 in/on dietary recommendations and exercise if it is not contradictory to the recommendations of your primary physician.

I, the undersigned client, understand the above statements. Whether or not I participate in this procedure or program is my decision. All decisions relative to my well-being and health must be made by me. I further understand that The Nutrition and Wellness Center staff are not medical doctors and are not attempting to portray them self or conduct the activities of medical doctors. I also understand that the medical device used in this procedure is intended for use in colon hydrotherapy, and that the Angel of Water is registered with the FDA and is intended for colon cleansing to promote general health and well-being and when medically indicated, such as before radiological or endoscopic examinations.

Whether or not I participate in the procedures offered by The Nutrition and Wellness 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.

Printed Name: _____

Signature & Date: _____

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The Nutrition and Wellness Center

Please read and review the policy information provided below carefully. We request that you acknowledge receipt of our policies by signing your acknowledgement below.

Fees and Payment
Our office accepts debit cards, and most major credit cards. We do not accept insurance for payment; however, when prescribed, insurance coverage may be possible for the procedure. Colon hydrotherapy may also be covered by some flex-spending accounts.

Initial colon hydrotherapy session with consultation: $125.00
Individual colon hydrotherapy session after initial session: $100.00
The Rookie: 3 colon hydrotherapy sessions: $270.00/$90.00 per session
The Veteran: 6 colon hydrotherapy sessions: $480.00/$80.00 per session
The Professional: 12 colon hydrotherapy sessions: $840.00/$70.00 per session

Cancellation Policy
In our clinic, we strive for 100% on-time colon hydrotherapy sessions and consultations. Accordingly, our cancellation policy is very strict and refunds will not be provided for missed sessions. Cancellations made 24 hours or more before the scheduled appointment will be rescheduled and the payment will not be charged.

LATE APPOINTMENTS
Late arrival for a scheduled appointment will be accommodated whenever possible; however, due to the scheduling of other clients a full colon hydrotherapy session/consultation may not be given to the client that has arrived past a scheduled appointment time.

REFUNDS
Pre-paid colonic sessions ***are non-refundable, are specific for the person who purchased pre-paid sessions.*** The 10-week protocol consisting of 12 colonics is recommended to be completed in 10-weeks; however, we extend to our clients the opportunity to use their 12 colonic sessions once a month for 12 months. 6 colonic sessions must be used within 6 months from date of purchase. 3 colonic sessions must be used within 3 months from date of purchase.

SERVICE POLICY
The Nutrition and Wellness Center reserves the right to determine if an individual is within our scope of practice and not allow a client that we feel is or potentially contraindicated to colon hydrotherapy.

Thank you for choosing The Nutrition and Wellness Center as your colon hydrotherapy provider. We are committed to your colonic session being successfully and comfortably completed.

Signature: _____ Date: _____

The Nutrition and Wellness Center

Two Day Diet and Activity Sheet

Name:_____Date:_____

Please thoroughly complete the diet and activity chart below. Provide as much detail as possible, including quantity/serving sizes and whether food is cooked or raw.

	Day 1	Day 2
Morning Meal Time:		
Snack Time:		
Mid Day Meal Time:		
Snack Time:		
Evening Meal Time:		
Snack Time:		
Water (cups)		
Fats & Oils used		
Condiments		
Type of exercise		
Duration of exercise		
Sleep (Hours)		
Time to bed		
Time for Relaxation		