Re New Life

Patient History
For Colon Hydrotherapy

Name: _____ Date: _____

Address: _____ City: _____ ST: ____ Zip: _____

Phone (Home): _____ (Work): _____ (email): _____

Occupation: _____ Place of Employment: _____

Height: _____ Weight: _____ Date of Birth: _____ Age: _____

Male/Female: _____ Number of Children: _____ Referred by: _____

Marital Status: _____ Who is responsible for this account?: _____

Have you ever received Colon Hydrotherapy? _____ If so, how many? _____ How Often? _____
Over what period of time? _____
Where? _____
How long has it been since your last colonic? _____
Do you: (Please indicate heavy, moderate, light, none)

Coffee/Tea _____	Alcohol _____	Exercise _____	Recreational Drugs _____
Soda _____	Anxiety _____	Rest _____	Stress Release: _____
Tobacco _____	Dieting _____	Meditation _____	HIV _____ (Optional)

Take your time and check any of the following you have had: In the last 30 days ✓ In the Past X

____ 1. Recent Constipation	____ 23. Family History of Colon Cancer	____ 45. Heart Disease
____ 2. Chronic Constipation	____ 24. Underweight	____ 46. Cancer
____ 3. Diarrhea	____ 25. Overweight	____ 47. Candida
____ 4. Parasites	____ 26. Diabetes	____ 48. Body Odors
____ 5. Colitis	____ 27. High Cholesterol	____ 49. High Blood Pressure
____ 6. Ulcerative Colitis	____ 28. Heartburn	____ 50. Low Blood Pressure
____ 7. Bowel Impactions	____ 29. Obesity	____ 51. Dizziness
____ 8. Hemorrhoids	____ 30. Frequent Headaches	____ 52. Fainting Spells
____ 9. Diverticulitis	____ 31. Migraine Headaches	____ 53. History of Seizures
____ 10. Bloody or Black Stools	____ 32. Nervousness	____ 54. Bloating
____ 11. Fistula or Fissures	____ 33. Insomnia	____ 55. Hepatitis
____ 12. Ulcers	____ 34. Irritability	____ 56. Shortness of Breath
____ 13. Hernia	____ 35. Anemia	____ 57. Chronic Cough
____ 14. Crohn's Disease	____ 36. Arthritis	____58. Emphysema
____ 15. Abdominal Pain	____ 37. Painful Menstruation	____59. Bronchitis
____ 16. Vomiting	____ 38. Vaginal Discharge	____60. Asthma
____ 17. Change in Stool	____ 39. Breast Pain	____61. Poor Circulation
____ 18. Gas, Belching	____ 40. Fatigue	____62. Enlarged Thyroid
____ 19. Low Blood Sugar	____ 41. Depression	____63. Double/Blurred Vision
____ 20. Kidney Failure	____ 42. Painful Urination	____64. Bruise Easily
____ 21. Kidney Infection or Stones	____ 42. Gallbladder Disease	____65. Skin Dryness
____ 22. Prostate Trouble	____ 44. Liver Trouble	____66. Skin Rash

PLEASE COMPLETE BOTH SIDES OF THIS FORM

IF YOU ARE A FEDERAL, STATE, OR LOCAL AGENT, UPON ENTERING THESE PREMISES, YOU MUST DECLARE SAME OR UNDER THE BIVENS ACT – ARTICLE 42, BE HELD PERSONALLY AND INDIVIDUALLY RESPONSIBLE

Are you now under a doctor's care? _____ If so, please explain _____

Doctor's name _____Telephone _____

Major physical complaints _____

Are you pregnant? _____ If so, what trimester? _____

List any surgeries you have had _____

List all medications & supplements you now take regularly (including over the counter) _____

_____

List all known allergies _____

How many bowel movements per day do you usually have? _____

Do you have to strain to have a bowel movement? _____

Do you use a stool softener or laxative? _____ Herbal laxative? _____ Suppository? _____

Do you have hemorrhoids or other rectal problems? _____

Have you ever had bleeding from any other bodily orifices? _____

If so, please explain _____

Have you ever had a barium enema? _____ If so, when? _____

What would you like to receive from this appointment for hydrotherapy? _____

_____

Colon hydrotherapy is a safe and effective method of cleansing your large intestine (colon). Your therapist does not diagnose disease or prescribe medication. It is your responsibility to provide pertinent health information and to inform the therapist of any changes. The office will provide a form to assist you in collection from your insurance company, however, services rendered are payable at the time of service unless special arrangements have been made.

RELEASE: I understand and agree that Colon Hydrotherapy services provided by this State Certified Colon Hydrotherapist are provided pursuant to and in accordance with the laws of the State of Florida governing Colon Hydrotherapy and that full and complete medical history disclosure is essential in providing such therapy. I agree to hold harmless, release and indemnify this State Certified Hydrotherapy. By signing this release I hereby declare that I have provided this State Certified colon Hydrotherapist with all relevant information necessary for the proper application of Colon Hydrotherapy and I expressly give my permission for this State Certified Colon Hydrotherapist to provide such therapy.

Failure to give 24 hours notice of cancellation will result in your being billed for the treatment.

Signature _____ Date _____

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Contraindications for Colon Hydrotherapy

- Severe cardiac disease: e.g. uncontrolled hypertension
- Congestive heart failure of organic valve disease
- Aneurysm
- Severe Anemia
- GI hemorrhage/perforation
- Severe hemorrhoids
- Cirrhosis
- Carcinoma of the colon or rectum
- Fissures/fistulas
- Advanced pregnancy
- Abdominal hernia
- Recent colon or rectum surgery
- Renal insufficiency
- Advanced Crohn's
- Advanced ileitis

If you have any of the conditions listed above,
Colon Hydrotherapy can NOT be done!

Please initial that you have reviewed the contraindication list

_____ _____

NAME DATE

RENEW LIFE

MISSED APPOINTMENT POLICY

It is the standard procedure of Renew Life to provide excellent care and courtesy to our clients. We go above and beyond the norm to attend to your needs. This includes arranging our schedule to accommodate anyone that needs our care.

One very important aspect that we need you to keep in mind is that we set aside an entire hour for your appointment. This means this time is reserved just for you. Because of this, we cannot possibly accept cancellations with less than 24 hours notice. If you cannot keep your appointment we very respectfully ask that you allow us that amount of time so that we may have an opportunity to fill that slow with someone else. With the exception of very serious emergencies, we expect you to adhere to your agreed upon appointment time or you will be asked to pay the full fee of the service.

Another point to be aware of is our appointments run back to back. If you are not on time to start your treatment we cannot penalize the person following your appointment. Therefore, the length of your treatment could be cut short if you are not here at your scheduled time.

Once again, we want you to be aware that we really care and want to provide the most optimum service and will be here to deliver what is needed. We respectfully as you to do the same with us.

Patients Signature _____ Date: _____