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HC Wellness Center & Spa

Achieving Health One Person At A Time.

1 Patient Information

Name:		DOB:
Cell Phone:	Cell Carrier:	Home Phone:
Street Address:		
City:	State:	ZIP Code:
Contact Email:		
Weight:	Height:	Occupation:
Blood Type:	How did You Here About Us (if referred, by whom)?:	

2 Activity & Nutritional Behaviors

What Types of Exercises/Activities do You Actively Participate In?

Length of Typical Workout?	# Sessions per Week?
Total Water Intake per Day (ounces)?	Do You Drink With Meals? ❑ No ❑ Yes: (Amount?

Check Your Common Beverages:

❑ Tap Water ❑ Distilled Water ❑ Reverse Osmosis ❑ Sparkling Water ❑ Herb Teas ❑ Other Tea ❑ Raw Juices ❑ Bottled Juices ❑ Coffee ❑ Beer ❑ Wine ❑ Other Alcohol ❑ Dairy ❑ Other:

Have You Fasted? ❑ No ❑ Yes	How Long?	How Often?
What percentage of your diet are fruits and/or vegetables?	How Many Servings per Day?	Percentage of time you don't eat food prepared at home?

Check Your Common Cravings:

❑ Sugar ❑ Salt ❑ Sweets/Chocolate ❑ Fat ❑ Carbonation ❑ Other: (

Check if you eat any on a weekly basis:						
❑ Sour Cream	❑ Turkey	❑ Beef	❑ Pizza	❑ Pastries	❑ French Toast	❑ Artificial Sweetener
❑ Cottage Cheese	❑ Cold Cuts	❑ Pork	❑ Ice Cream	❑ Pancakes	❑ Muffins	❑ MSG
❑ Whipped Cream	❑ Eggs	❑ Lamb	❑ Pie	❑ Pretzels	❑ Bagels	❑ Splenda
❑ Mayonnaise	❑ Butter	❑ Chicken	❑ Candy	❑ White Bread	❑ Fries	❑ Dressing
❑ Cream Cheese	❑ Margarine	❑ Fish	❑ Cookies	❑ Waffles	❑ Chips	❑ Soy Sauce
	❑ Cheese	❑ Yogurt	❑ Donuts	❑ Popcorn	❑ Salt	❑ Olestra
	❑ Kefir	❑ Milk	❑ Cake	❑ Cereal	❑ Worcestershire	❑ Ketchup, Mustard, Tartar Sauce

Check if You are the Following:

❑ Soy-Free ❑ Gluten-Free ❑ Lactose-Free ❑ Gluten Intolerant ❑ Lactose Intolerant ❑ Vegetarian ❑ Vegan ❑ Other: (

Check if You have Experienced Any of the Following (past or present):

❑ Constipation ❑ Overeating ❑ Binge Eating ❑ Anorexia or Bulimia ❑ Late Night Eating ❑ Diet Programs

Eating When: ❑ Fatigued ❑ in Pain ❑ Not Hungry ❑ Emotionally Upset

Typical Breakfast:	Time:
Typical Lunch:	Time:
Typical Dinner:	Time:
Typical Snacks:	Time(s):

3 Intestinal Conditions

How Often do You Eliminate (Daily)?	(Weekly)?	Family History of Intestinal Issues? ❑ No ❑ Yes: (Issue?

"My Bowel Movements Are" *(check all that apply)*

❑ Effortless ❑ Occur Only After Eating ❑ Spontaneous ❑ Require Straining ❑ Painful ❑ Incomplete ❑ Other: (

Check if You Use Any of the Following *(past or present)*

❑ Food Enzymes ❑ Probiotics ❑ Antacids ❑ Fiber ❑ Bentonite ❑ Laxatives ❑ Enemas ❑ Stool Softeners

Check if you experience *(past or present)**:* ❑ Fatigue After Eating ❑ Hungry All the Time ❑ Indigestion ❑ Gas ❑ Gripping/Cramping ❑ Bloating ❑ Reflux/Heartburn	❑ Constipation ❑ Diarrhea ❑ Constipation & Diarrhea ❑ Spastic Colon ❑ Lazy Colon ❑ Hard Stool ❑ Black Stool ❑ Intestinal/Rectal Bleeding ❑ Anal/Rectal: Itching/Burning	❑ Rectal Pain ❑ Ulcer ❑ IBS ❑ Celiac Disease ❑ Prolapsus/Redundancy ❑ Colon/Rectal Carcinoma	❑ Acute Fecal Impaction ❑ Parasite Infection ❑ Crohn's Disease ❑ Diverticulosis/-itis ❑ Colitis/ Mucus/ Ulcerative ❑ Colon/Rectal Surgery ❑ Perforation ❑ Fissure ❑ Fistula	❑ Hernia ❑ Hemorrhoids ❑ Other:

4 Medical & Social History

Check if you experience *(past or present)**:* ❑ Swollen Glands ❑ Sinus Problems ❑ Allergies ❑ Earache ❑ Headaches/Migraines ❑ Body Odor ❑ Bad Breath ❑ Belching	❑ Impaired Hearing ❑ Vision Problems ❑ Fatigue ❑ Insomnia ❑ Anemia ❑ Infections ❑ Nail Fungus ❑ Dry Skin ❑ Acne/Problematic Skin ❑ Eczema	❑ Varicose Veins ❑ Antibiotic Use ❑ Yeast Infection ❑ Water Retention ❑ Nausea ❑ Difficult Menstruation ❑ Cysts/Tumors ❑ Arthritis ❑ Aneurysm** ❑ Bell's Palsy	❑ Cancer ❑ Chronic Fatigue ❑ Diabetes ❑ Epstein Barr ❑ Fibromyalgia ❑ Gall Bladder Problems ❑ Herpes ❑ Hepatitis/Cirrhosis** ❑ HIV/AIDs ❑ Hypoglycemia	❑ Hypertension/Cardiac Disease ❑ Kidney Disease ❑ MS ❑ Parkinson's ❑ Prostate Problems ❑ Other:

Are You Currently Pregnant? ❑ No ❑ Yes	If Yes: How Many Weeks?	Previous Pregnancies?
Check & Date the Following Operations: ❑ **Gall Bladder:**	❑ **Appendix:**	❑ **Hysterectomy:**
❑ **Rectocele:**	❑ **Cystocele:**	❑ **Intestines:**
❑ **Back:**	❑ **Spleen:**	❑ **Cyst:**
❑ **C-Section:**	❑ **Laparoscopy:**	❑ **Other:**

Check if You Experience Excessively *(past or present)*

❑ Depression ❑ Irritability ❑ Restlessness ❑ Codependency ❑ Anxiety ❑ Fearfulness ❑ Despair ❑ Mental Confusion ❑ Grief ❑ Anger ❑ Hurt ❑ Sadness ❑ Forgetfulness ❑ Obsessive Compulsive Behavior ❑ Bipolar Disorder

Are You Currently Under Excessive Stress? ❑ No ❑ Yes	How Do You Respond to Stress?

List any herbs, vitamins, & supplements used:	***List any prescription or over-the-counter medications used:***
List any allergies you have to food, medications, etc:	***Do any of your medications slow or speed your elimination?***

APPOINTMENT POLICY & AGREEMENT *(Please Read Carefully)*:

- **A credit card is required to hold a scheduled appointment time.** You may change the form of payment after your appointment.
- **Cancellations/Missed Appointments:** In order to maintain later hours and for the courteousness of both our clients and staff; a minimum of 24 hours notice is required to cancel any appointment. Cancellations made **less than 24 hours** prior to the scheduled time will be **charged a 50% fee**. **"No-Show's"** will be **charged 100%** of the session. Pre-paid packages will have a session deducted from your package plan.
- **Late Policy:** If you are late for an appointment, the time will be deducted from your session, as we cannot extend the allotted appointment time. If you are more than 15 minutes late, you may need to reschedule your appointment. It is very important to us to meet the needs of ALL of our clients by keeping waiting times to a minimum.

Disclaimer – Colon Hydrotherapy is not intended to replace the relationship with your primary health care providers and consultations are not intended as medical advice. They are intended as a sharing of knowledge and information from our Colon Hydrotherapist's education, research, experience and community. The information and service provided is not used to prescribe, recommend, diagnose or treat a health problem or disease. It is not a substitute for medical care. If you have or suspect you may have a health problem, you should consult your primary health care providers.

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	Parent Name **PRINTED:**	**Parent Name** **SIGNATURE:**	**Date:**