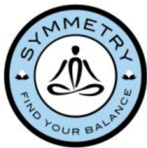

CONFIDENTIAL HEALTH INTAKE FORM

All information is kept strictly confidential and will become part of your personal file. In order to provide the best possible care and to insure optimum results from your sessions, the following information is essential and should be completed completely and accurately.

Contact Information

Name: ____ Date: __________________

Address: ____ City / State / Zip __________________________

Phone: *(1)* ___ - ____ - ______ *(2)* ___ - ____ - ______ Email: ____

Age: _________ Date of Birth: _____ / ______ / ________ Height: _______________ Weight: ________________

Sex: ☐ Male ☐ Female Marital Status: _________ **How did you hear about us?** ___________________________

Occupation: ____

What are your primary activities at work? ☐Walking ☐Lifting ☐Standing ☐Typing/Computer ☐Other: ________________

Emergency Contact Information

Name: ____

Relationship: ___________________________ Phone: *(1)* _____ - _____ - _________ *(2)* _____ - _____ - _________

Are you currently pregnant? ☐No ☐ Yes

Are you currently under medical care? (Doctor's / Chiropractor / Herbalist)? ☐No ☐ Yes, Name: _____________________

Phone: _______ - _______ - ___________ Date of last complete physical exam: ______ / _______ / __________

Results: ____

Is your physician aware of you receiving this service? ☐Yes ☐ No

Please list your reason for and expectations from receiving this service today: _____________________________________

____

Please read and sign:

Please understand that in answering questions we do not diagnose or prescribe, but offer information only to help you to cooperate with your doctor in your mutual quest of building optimum health. It is your choice to use this information without your doctor's approval, which is your constitutional right, but we assume no responsibility.

I agree and understand the information presented to me. I declare the information I have disclosed herein to be true and accurate to the best of my knowledge.

_____________________________ / _____________________________________ / _________________

Client Name (Print) / Client Signature / Date

Are you interested in receiving more information regarding our other services? (Check all that apply)

□Alkaline Water Store	□Colon Hydrotherapy	□Chiropractic	□Nutritional Counseling
□Infrared Sauna	□Massage & Bodywork	□Reiki and Energy	□Holistic Life Coaching
□Psychotherapy	□Migun Thermal Massage Table	□Raw foods consulting	□Other: ______________________

VITAL HEALTH INFORMATION

List recent *(in past 6 months)* or previous relevant surgeries, major illnesses, or other hospitalizations:

Have you ever been treated for any of the following conditions? *(Check all that apply)*

- Headaches
- Chronic Pain
- Varicose Veins
- Muscle or Joint Pain
- Blood Clots
- Sinus
- Numbness/Tickling
- High/Low Blood Pressure
- Jaw Pain/Teeth Grinding
- Sprains/Strains
- Diabetes
- Fatigue
- Scoliosis
- Cancer/Tumors
- Depression
- Arthritis
- Infectious Disease
- HIV/AIDS
- Sleep Difficulties
- Tendonitis
- Upper Back Pain
- Mid Back Pain
- Lower Back Pain
- Sciatica

Please elaborate on above items: ____

Prescription Medications or Supplements/Over the Counter medications:____

____

List all known allergies: ____

✓ Complete this box if you are receiving a MASSAGE today

Have you ever had a massage before today? No Yes Date of last massage: ___________________________________

Is your visit a result of a work related injury? No Yes, please explain: ______________________________________

Is your visit today the result of a sports injury? No Yes

What physical movements limit you: ____

What movements aggravate your condition the most? ____

What seems to help the most? ____

I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes. I know I am responsible for payment of all fees resulting from my treatment on the date of service.

______________________________ / ______________________________________ / _________________

Client Name (Print) / Client Signature / Date

✓ Complete this box if you are receiving COLON HYDROTHERAPY today

Have you ever had colon hydro-therapy before? No Yes, when/where: ______________________________________

Have you ever been treated for any of the following conditions? *(Check all that apply)*

- Rectal Bleeding
- Cancer
- Appendicitis
- Ileitis
- IBS
- Cohn's Disease
- Ulcerative Colitis
- Leaky Gut Syndrome
- Severe Anemia
- Diverticulitis
- Renal Insufficiency
- Colitis
- Fissures/Fistulas
- Cardiac Disease
- GI Hemorrhage/Perforation
- Cirrhosis
- Abdominal Hernia
- Aneurysm
- Hepatitis (what type)
- Liver Trouble
- Gall Bladder Disease
- Vomiting Blood
- Dizziness/Fainting Spells
- History of Seizures
- Fatigue
- Enlarged Thyroid
- Difficulty Urinating
- Emphysema
- PMS
- Kidney Infection
- Kidney Stone
- Kidney Failure
- Constipation
- Diarrhea
- Hemorrhoids
- Other: ______________

Please explain all checked conditions: ____

Have you ever had? *(Check all that apply)* Colonoscopy Sigmoidoscopy Rectal Surgery Hemorrhoid Surgery

If So, Date: _______________ Results: ____

Do you take any of the following? Laxatives Diuretics? Fiber Stool softeners Pysllium

If So, What type?__________________ Since When/How often? ____

How often do you have a bowel movement? ____

Have you had difficulty having bowel movements recently? (Bleeding, pain, straining) _________________________________

Colon hydrotherapy can assist in building or restoring optimum health. Multiple sessions combined with good eating habits and regular exercise is necessary to achieve optimum results. It is advised before beginning diet, exercise or complimentary modality, to discuss it with your physician.

_______________________________ / ____ / __________________

Client Name (Print) / Client Signature / Date