THE CLEANSE-IN-PLACE

PERSONAL HISTORY FORM

Name: _____ Date:_____/_____/_____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

DOB: _____ Age: _____ Sex: ____ Marital Status: _____

Occupation: _____ Referred by: _____

Please *circle* all of the following symptoms that currently apply to you. On a scale from 1-10, with 10 being the worst, please rate the severity of your symptoms.

Headaches	**Skin Eruptions**	**Frequent Urination**	**Fever**	**Itching**
Painful Urination	**Chills**	**Bruises Easily**	**Bloody Urine**	**Sweats**
Dryness	**Kidney Problems**	**Fainting**	**Boils**	**Urine Control Problems**
Allergies	**Sensitive Skin**	**Chronic Cough**	**Insomnia**	**Acne**
Heart Problems	**Fatigue**	**Depression**	**Unexplained Weight Loss**	
Nervousness	**Chest Pain**	**Difficult Breathing**	**Overweight**	**Pain Over Abdomen**
Constipation	**Diarrhea**	**Hemorrhoids**	**Colon Trouble**	**Rectal Bleeding**
Bloody Stool	**Intestinal Worms**	**Liver Trouble**	**Jaundice**	**Gall Bladder Trouble**
Poor Appetite	**Excessive Hunger**	**Difficult Digestion**	**Belching/Gas**	**Nausea/Vomiting**

Any other symptoms? _____

HIV positive, Hepatitis A, B, or C, etc.

FOR WOMEN ONLY

Hot Flashes	**Irregular Cycle**	**Painful Menstrual Periods**
Cramps	**Miscarriage**	**Excessive Menstrual Flow**
Vaginal Discharge	**Lumps in Breast**	**Menopausal Symptoms**

Are you pregnant? _____

Please *circle* all of the following conditions you have or have had:

AIDS
Alcoholism
Anemia
Anorexia
Appendicitus
Arthritis
Arteriosclerosis
Asthma
Bleeding Disorders
Bronchitis
Bulimia
Cancer
Cataracts
Chemical Dependency
Chickenpox
Colitis
Diabetes
Diptheria
Eczema
Emphysema
Epilepsy
Fever Blisters
Flu
Glaucoma
Goiter
Gonorrhea
Gout
Heart Problems
Hepatitis
Hernia
Herpes
High Cholesterol
HIV Positive
Kidney Problems
Liver Problems
Lupus
Mental Disorders
Measles
Malaria
Migraines
Miscarriage
Mononucleosis
Multiple Sclerosis
Mumps
Nervous Breakdown
Pacemaker
Pleurisy
Pneumonia
Polio
Prostate
Psychiatric Care
Rheumatic Fever
Scarlet Fever
Smallpox
Stroke
Suicide Attempt
Thyroid Problems
Tonsilitus
Tuberculosis
Typhoid Fever
Ulcers
Venereal Infection
Whooping Cough
Other _____
_____
_____
_____
_____

The following is a list of contraindications for using this procedure. If you have ever been diagnosed with ANY of these conditions, a Doctor's prescription/release will be required to use this procedure.

Abdominal Hernia
Abdominal Surgery (Recent)
Abnormal Distention/Masses
Acute Liver Failure
Anemia (Severe)
Aneurysm
Carcinoma
Cardiac Condition
Chrohns Disease
Colitis
Dialysis Patient
Digestive Problem History
Diverticulosis
Fissures
Fistulas
Hemorrhaging
Hemorrhoid Surgery
Intestinal Perforations
Lupus
Pregnant (Currently)
Rectal Surgery
Renal Insufficiencies

I _____ have read the above contraindications for colon cleansing enemas and, by my signature below, I testify that I DO NOT HAVE ANY of the above conditions. I am also aware that the use of colon cleansing enemas is by my own personal choice and that the technician is not a medical doctor nor portrays themselves as such. Colon cleansing enemas have not been clinically tested to provide ANY medical benefits. This facility does not claim that the colon cleansing will cure or treat any condition or disease. This procedure is used solely for the purpose of evaluating the lower bowel. I am aware that adverse events such as perforation, injury, illness, and death have been alleged and claimed with the use of colon cleansing and enema devices.

Signature: _____

Print name: _____

Date: _____

If you are currently taking any medication for any condition (prescription or OTC) you may want to check with your doctor before using any colon cleansing service. If you have ever been diagnosed with any intestinal condition or have taken any medication that can weaken the intestinal walls, you should check with your Primary Health Care Provider before colon cleansing. If you are not sure of the side effects of the drugs you are using, you can check on the internet or with your local pharmacist or doctor.

HABITS

How many hours of sleep do you get daily? _____

Do you exercise daily? Yes _____ No _____

If so, how long each day? _____

How much water do you drink daily? _____

What types of foods do you eat? _____

How many bowel movements do you have daily? _____

Do you use any of the following on a daily basis?

Alcohol? _____ /day

Coffee? _____ cups/day

Tea? _____ cups/day

Tobacco _____ /day

Do you take any Daily Supplements (Vitamins. Minerals, Herbs, etc.)? Yes _____ No _____

If so, please indicate what you take and what you take it for. _____

Do you take any Medications? Yes _____ No _____

If so, please indicate your prescription and the condition for which you take it.

_____

Have you had professional colon hygeine/lower bowel evacuation session before?

Yes _____ No _____ Where and When _____

What is your primary reason for using this service? _____

What is your #1 Health Goal or Concern at this time? _____

Client Signature:_____