Internal Wellness Center

Health History - Your Health History is Confidential

Name: _____Birth Date:_____Today's Date: _____

Address: _____City: _____ State: _____ Zip: _____

Work Phone: (_____)_____ Home Phone: (_____)_____ Cell Phone: (_____)_____

Occupation: _____ Referred by: _____

Have you recently travelled (Date)? _____ If so, your destination?_____

Please place an X in front of each and every symptom/health condition you have or have previously experienced.

General Symptoms

_____ Headache
_____ Fever - Currently
_____ Chills
_____ Sweats
_____ Fainting
_____ Allergies
_____ Dizziness
_____ Convulsions
_____ Loss of Sleep
_____ Fatigue
_____ Nervousness/Depression
_____ Weight Gain/Loss
_____ Numbness in _____

Skin

_____ Itching
_____ Bruises Easily
_____ Dryness
_____ Varicose veins
_____ Sensitive skin
_____ Hives or allergy

Respiratory

_____ Chronic cough
_____ Spitting up phlegm
_____ Spitting up blood
_____ Chest pain
_____ Difficult breathing

Cardio-Vascular

_____ Rapid heartbeat
_____ Slow heartbeat
_____ High blood pressure
_____ Low blood pressure
_____ Pain over heart
_____ Heart attack
_____ Swelling ankles
_____ Poor circulation

Eyes, Ears, Nose & Throat

_____ Crossed eyes
_____ Eye pain
_____ Deafness
_____ Failing vision
_____ Far sightedness
_____ Near sightedness
_____ Earache
_____ Ear noises
_____ Ear discharge
_____ Nose bleeds
_____ Nasal drainage
_____ Sore throat
_____ Swollen tonsils
_____ Enlarged lymph glands
_____ Enlarged thyroid
_____ Colds
_____ Sinus infection
_____ Hay fever
_____ Asthma
_____ Dental Decay
_____ Gum problems

Genito-urinary

_____ Frequent urination
_____ Painful urination
_____ Blood in urine
_____ Kidney problems
_____ Inability to control urine
_____ Urinary Tract Infection (UTI)
_____ Prostate problems

Muscle, bone & joint

_____ Stiff neck
_____ Backache
_____ Swollen joints
_____ Tremors
_____ Painful tailbone
_____ Foot & ankle problems
_____ Pain in: shoulders, arms, elbows, hands, hips, legs, knees, feet, or other:
_____ Hernia
_____ Spinal curvature
_____ Faulty posture
_____ Subluxation
_____ Pinched nerves

Gastro-intestinal

_____ Poor appetite
_____ Excessive hunger
_____ Difficult digestion
_____ Belching or gas
_____ Distention of abdomen
_____ Nausea
_____ Vomiting
_____ Pain over stomach
_____ Vagus Nerve/Vasovagal Reflex
_____ Constipation
_____ Diarrhea
_____ Colon problems
_____ Hemorrhoids or piles
_____ Rectal bleeding
_____ Bloody stools
_____ Intestinal worms/parasites
_____ Liver problems
_____ Gall bladder problems
_____ Jaundice
_____ Diverticulosis/Diverticulitis
(If you have diverticulosis or Diverticulitis you are not a candidate for colon hydrotherapy)

This section for Women Only - If not female please continue to next section

_____ Painful menstrual periods	_____ Irregular cycle	_____ Vaginal discharge
_____ Excessive menstrual flow	_____ Cramps or backache	_____ Lumps in breast
_____ Hot flashes	_____ Miscarriage	_____ Menopausal symptoms

For everyone. Please place an "X" in either the Yes or No space for each of the following questions.

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

To the best of my knowledge, all the preceding answers are correct.

Client signature: _____ Date:_____

Colonics are a perfectly safe and natural procedure however, there are some conditions that may not be benefited by the colonic process. Contraindications to colon hydrotherapy include congestive heart failure, intestinal perforation, carcinoma of the rectum, fissures or fistula, severe hemorrhoids, abdominal hernia, renal insufficiency, recent colon or rectal surgery, cirrhosis of the liver, and first and last trimester of pregnancy.

Curing disease or any other illness is between you and your health care medical professional. Internal Wellness Center does not treat any diseases or illnesses, nor do we make any diagnosis of any illness. Internal Wellness Center is not staffed by medical doctors, and is not attempting to portray itself as a medical professional, nor does it conduct the activities of medical doctors. Colonic hygiene is considered complementary to the recommendations and/or programs of your health care medical professional.

150 Wood Road, Suite 403 • Braintree, MA 02184 • tel.781.228.6915 • fax.781.228.6916
www.internalwellnessctr.com

Internal Wellness Center

Informed Consent

Neither Internal Wellness Center nor its associates, do any of the following, whether implied or intended:

- We do not diagnose.
- We make no attempt to cure any condition.
- We make no claims or imply any claims that suggest a cure for any condition.
- We do not claim that any supplemental material we speak about will cure any condition, or that its purpose is to treat any condition.
- 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 physician(s).
- I, the undersigned client, understand the above statements.
- I, as the undersigned client, understand that diet and nutrition is considered to be an inexact science, and that the results obtained are not always constant or predictable.
- I also understand that there is no guarantee of any results and that the opposite of my desired results may occur.
- Whether or not I participate in this procedure and/or program is my decision, based on my constitutional right of the Ninth Amendment. I must make all decisions relative to my wellbeing and health.
- I further understand that Internal Wellness Center staff are not medical doctors and are not attempting to portray themselves or conduct the activities of medical doctors.
- I also understand that the medical device used in this procedure is intended for use in colon irrigation.
- Additionally, I understand the Angel of Water system is registered with the FDA and is intended for colon cleansing to promote general health and wellbeing and when medically indicated, such as preparation for radiological or endoscopic examinations.
- I understand colonic hygiene is considered complementary to the recommendations and/or programs of my health care/medical professional(s).

If any representations have been made to me concerning this program, or if I have any understanding about this program which representations and/or understandings are contrary to the above statements, I will indicate so at the bottom or reverse side of this form. By signing this form, I state that I am not a D.O.H. agent or Federal Agent or in the services of these agencies, but that I am a client seeking colon hydrotherapy services for my own benefit. I have read this agreement in full and agree to its terms.

Print Name:_____Street Address _____

City _____ State _____ Zip_____Email address: _____

Work Phone: (_____) _____ Home Phone: (___) _____ Cell Phone: (_____) _____

Signature: _____ Date: _____

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Policies

Please read, initial each section where indicated and sign below.

Our Financial Policy

Thank you for choosing Internal Wellness Center as your colon rejuvenation provider. We are committed to your colonic session being successfully completed. Please understand that the prompt payment of your bill is the only way we can continue to provide the best quality and service.

_____ We require full payment at the time of service. We accept cash, Master Card, VISA, Discover and American Express. **No personal checks please**.

Missed and/or Late Appointments

_____ Unless **cancelled at least one business day in advance**, we will charge for missed appointments at the full rate of the scheduled appointment. Please help us by keeping your appointment.

_____ Late arrival for a scheduled appointment will be accommodated whenever possible. However, due to the scheduling of other clients, late arrivals may need to be rescheduled.

Service Policy

_____ Internal Wellness Center reserves the right to refuse to offer our services to individuals with conditions that we feel may be contraindicated to colon hydrotherapy. Clients who we feel are out of our scope of practice may not receive services without the express written original prescription from a medical practitioner.

Signature: _____ Date _____

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