



New Life Wellness Center

Personal History Form

Name Date.....

Address Apt#.....

CityState..... Zip.....

Home Phone.....Work Phone.....

Date of birthAge Sex

Marital statusSpouse..... # Of Children.....

Occupation..... Referred By

Email Address

Please check (√) all of the symptoms which you now have or have had in the past one year. Be as thorough as possible. **YOUR HEALTH HISTORY is confidential.**

General Symptoms

- Allergy
- Chills
- Depression
- Dizziness
- Fainting
- Forgetfulness
- Headache
- Loss of Weight
- Nervousness
- Overweight
- Sweats

Eyes, Ears, Nose and Throat

- Asthma
- Colds
- Cross Eyes
- Deafness
- Dental Decay
- Ear Discharge
- Ear Noises
- Ear Ache
- Enlarged Lymph Glands
- Enlarged Thyroid
- Eye Pain
- Failing Vision
- Far Sighted
- Gum Trouble
- Hay Fever

- Hoarseness
- Nasal Obstruction
- Nasal Drainage
- Near Sighted
- Nose Bleeds
- Sinus Infection
- Sore Throats
- Swollen Tonsils

Skin

- Acne
- Boils
- Bruises Easy
- Dryness
- Hives
- Itching
- Sensitive Skin
- Skin Eruptions
- Varicose Veins

Respiratory

- Chronic Cough
- Difficulty Breathing
- Spitting Up Blood
- Spitting Up Phlegm

Cardiovascular

- High Blood Pressure
- Low Blood Pressure
- Pain Over Heart

- Poor Circulation
- Rapid Heartbeat
- Slow Beating Heart
- Stroke/Heart Attack
- Swelling of Ankles

Muscles, Bone and Joints

- Pain, weakness, numbness in*
- Abdomen
- Arms
- Back
- Chest
- Elbows
- Feet
- Hands
- Hips
- Knees
- Legs
- Shoulders
- Spinal Curvature

Genitourinary

- Blood/Pus in Urine
- Control of Urine
- Frequent Urination
- Kidney Trouble
- Painful Urination
- Penal sores
- Prostate Trouble

Gastrointestinal

- Belching or Gas
- Bloody Stools
- Colon Trouble
- Constipation
- Diarrhea
- Difficult Digestion
- Distension of Abdomen
- Excessive Hunger
- Gall Bladder
- Hemorrhoids or Piles
- Intestinal Worms
- Jaundice
- Liver Trouble
- Poor Appetite
- Rectal Trouble

For Women Only

- Cramps or Backache
- Excessive Menstrual Flow
- Hot Flashes
- Irregular Cycles
- Lumps in Breast
- Menopausal Symptoms
- Miscarriage #
- Painful Menstrual Periods
- Vaginal Discharge
- Vaginal Sores

List any other symptoms.....

CIRCLE ANY OF THE CONDITION ANY OF THE CONDITIONS YOU HAVE NOW OR HAVE HAD

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arteriosclerosis
- Arthritis
- Asthma
- Bleeding Disorders
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Colitis
- Diabetes
- Diphtheria
- Eczema
- Emphysema
- Epilepsy
- Fever Blisters
- Flu
- Glaucoma
- Goiter

- Gonorrhea
- Gout
- Heart Problems
- Hepatitis
- Hernia
- Herpes
- High Cholesterol
- HIV Positive
- Kidney Problem
- Liver Problem
- Lupus
- Malaria
- Measles
- Mental Disorders
- Measles
- Migraines
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Nervous Breakdown
- Pacemaker
- Pleurisy
- Pneumonia
- Polio
- Prostate

- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Small Pox
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tuberculosis
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Venereal Infection
- Whooping Cough

Others (not listed).....

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

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

I _____ have read the above contraindications for colonic irrigation and by my signature below I testify that I DO NOT have ANY of the above conditions. I am also aware that colonic irrigation is by my own personal choice and that the technician is not a medical doctor, nor portrays themselves as such. Colonic irrigation has not been clinically tested to provide ANY medical benefits. The facility does not claim that the use of colonic irrigation will cure or treat any condition or disease.

Print Your Name _____

Signature _____

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

- | | |
|--------------|--------------------|
| Alcohol..... | Supplements |
| Coffee..... | Vitamins..... |
| Tea | Minerals..... |
| Tobacco..... | Herbs..... |

Disclaimer

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

Cancellation policy

I understand that New Life Wellness Center has a cancellation policy which states that 24 hours cancellation is required for any appointment. Should I have an appointment on a Monday I understand I will need to cancel at the very latest on the previous Saturday before the equivalent time of my appointment on the Monday. If I cancel within 24 hours of my appointment as detailed above I understand my payment card will be charged a cancellation fee or that I will lose that part of my pre-paid course of treatments unless New Life Wellness Center is able to refill my cancelled appointment slot. I further understand that the full cancellation fee will be charged to my payment card if I do not attend my scheduled appointment and have not given New Life Wellness Center at least 24 hours notice as described above.

Consent declaration

The information provided above is to the best of my knowledge true and accurate. I have read and agree with the above cancellation policy. The procedure for colon hydrotherapy has been explained and I hereby give my consent for a digital examination and colon hydrotherapy to be performed on myself. I have read the above and confirm that I do not suffer from any condition that may prevent me from receiving colon hydrotherapy. I will keep New Life Wellness Center and my therapist informed of any changes in my health.

Signature Date