Client Health Questionnaire

CONTACT INFORMATION

NAME: _____ **Today's Date:** _ _ / _ _ / _ _ _ _

ADDRESS: _____

PHONE: _____(h)_____(c)_____(w)

E-MAIL_____**AGE**_____ **DATE OF BIRTH**_____

HEIGHT: _____ **WEIGHT:** _____ **SEX: F**_____**M**_____**OCCUPATION**_____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____**PHONE** _____

HAVE YOU EVER HAD COLON HYDROTHERAPY? ___YES __NO (IF YES EXPLAIN WHERE AND WHEN) _____

PLEASE STATE YOUR REASONS FOR AND EXPECTATIONS FROM RECEIVING COLON HYDROTHERAPY:

_____

_____

IS YOUR PHYSICIAN AWARE OF YOU RECEIVING COLON HYDROTHERAPY? _____ YES _____NO

Health information

In order to provide the best possible care and to insure optimum result from you colon hydrotherapy session, the following information is essential. Please complete this section thoroughly and completely. All information confined herein, is strictly confidential.

FOR WOMEN ONLY

YES	NO	
		ARE YOU PREGNANT?
		DO YOU TAKE BIRTH CONTROL PILLS?
		Do you suffer from PMS?
		Do you take Hormone supplement?
		Are your periods regulars?

HAVE YOU EVER HAD A COLONOSCOPY? (IF YES THEN EXPLAIN) _____Yes_____No

_____

Pleas list all and for what purpose

Prescription Medications: _____
Supplements: _____
Over the Counter Medications: _____
All known allergies:_____
List the type and year of all surgeries and major illness:

_____

_____

DIGESTIVE SYSTEM ASSESSMENT:

Please describe your dietary intake: (example; vegan, vegetarian, food combining, non-vegetarian, beef, pork, poultry, home cooking, dinning out, fast food, etc.) How many times do you eat each day?

Daily Water Consumption: Cups_____ or Gallons_____
Beverages: ____water ____ soda_____ energy drinks_____ café _____ tea_____ alcohol
Do you exercise? _____Yes_____ No How many times a week_____

How often do you have a bowel movement? _____

Do you suffer from constipation? ____YES ____NO ___ OCCASIONALLY

YES	NO	
		Do you suffer from diarrhea?
		Do you suffer from alternating periods of constipation and diarrhea?
		Do you have hemorrhoids? Internal/ External / Both- Mild/Moderate/Sever
		Have you ever had hemorrhoids surgically corrected? When?
		Do you take laxatives?
		Do you take fiber?
		Do you strain to have a bowel movement?

Do you suffer from Flatulence, belching and/or bloating? _____
Do you have to avoid certain foods? _____
Do you have to minimize certain foods? _____
Do you suffer from Heartburn, reflux, and regurgitation? _____
Do you suffer from Irritable Bowel Syndrome? _____
Do you have Fatigue &/or low energy? _____
Have you ever been treated for Appendicitis? _____
Have you ever been diagnosed with colon cancer? _____

Contraindications

We will NOT perform colon hydrotherapy with you if you have any of the listed contraindications UNLESS you have a PRESCRIPTION from your licensed physician or your condition has subsided or been eliminated at the present time.

Do you have any of the following conditions at the present time?

Yes	No	
		Congestive heart failure of organic valve disease
		Severe cardiac disease; e.g. uncontrolled hypertension
		Aneurysm
		Take blood medication
		Severe anemia
		GI hemorrhage/perforation
		Severe hemorrhoids
		Ulcerative colitis
		Crohn's disease
		Cirrhosis
		Deverticulitis
		Hepatitis A, B, C
		Carcinoma of the colon or rectum
		Fissures/fistulas
		Abdominal hernia / inguinal hernia
		Colon surgery
		Recent abdominal surgery (at least the 3 months post surgery)
		Recent colonoscopy (at least the 12 days post Colonoscopy)
		Tumor in the Rectum or Large Intestine
		Renal insufficiency
		Kidney dialysis
		HIV
		AIDS
		Epilepsy
		History of seizures
		Abortion (less than 6 months)
		Miscarriage (less than 4 months post-op)
		Breast feeding
		Pregnancy
		Immunocompromised at present time
		Present gastrointestinal infection
		Rectal bleeding
		Severely obese
		Vomiting at present time
		Strong abdominal pain

I understand Colon hydrotherapy is a process, not a quick cure; it is used as a detoxification process, rejuvenation and restoration of good colon health. Multiple sessions combined with good eating habits and regular exercise is necessary to achieve optimal results. It is advised before beginning diet, exercise, or complimentary modality, to discuss it with your physician. The number of colonics you may need depends on your goals, intestinal health, dietary habits, and lifestyle choices.

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

(Print Name) _____
(Signature) _____ Date_____

CONSENT AND RELEASE

Client Name_____

Address_____

City, State, Zip _____

I, (client name)_____, certify I am over 18 years of age.
Or, I am the father/mother/legal guardian of my sun/ daughter (Minor's name)____
_____.
Parent or legal guardian must be present with the child during the entire treatment and I have fully disclosed their medical history and have completely and accurately answered all health related questions. I will alert *Biltmore Wellness Center L.L.C.* of any changes to their health, medications and/or lifestyle as they occur**. No child may be left unattended at any time.**

For receiving instructions and sessions here, I release and forever discharge Elena Agee and all others associated with Biltmore Wellness Center L.L.C. from any and all responsibility or liability arising from these procedures, or to sign this release form. No guarantees or warranties have been made to me or to the success, value, or benefits of such procedures.

I realize and acknowledge that instructions, recommendations and services are not medical treatments or prescriptions. Any changes or additions in my diet, exercise, or supplementation are of my own choosing.

I am undergoing treatment(s) of my own free will. I understand that although every precaution will be taken to prevent complications, they can and sometimes occur. I accept responsibility for any complication that may occur and hereby absolve *Biltmore Wellness Center L.L.C.* and any associated persons of any blame for any complications resulting from my treatments.

I understand and acknowledge that the results of treatments and procedures may vary and are subjective and that no guarantees or assurance has been given or implied with regards to the results, effectiveness, satisfaction or duration of the achieved results. I have been instructed to and understand I must consult my physician before entering into any lifestyle changes and am free to withdraw my consent and discontinue visits here at any time. This form has been fully explained to me and I certify that I understand its contents.

_____
_____
Client Signature Today's Date

PAYMENT & OFFICE POLICIES

(Please Read and Sign)

Biltmore Wellness Center L.L.C. may modify these policies at any time.

Once you schedule an appointment with "Biltmore Wellness Center," that time and date have been reserved for you. To cancel or reschedule, please call 24 hours prior to your appointment time. Appointments cancelled without notice within 24 hours are subject to a cancellation fee. **A $35.00 charge for all cancellations or rescheduling will be made on the day of the appointment. I understand and agree that my** appointments must be prepaid at the time of scheduling and billing information may be required. I understand "Biltmore Wellness Center" may ask me to provide identification as a new client. I may be asked to submit a valid driver's license or other form of identification before my first treatment, a copy of which will be kept in my confidential treatment file.

I understand that the therapist of "Biltmore Wellness Center" administering the colon hydrotherapy session is not physician and does not provide medical services of any kind.

Clients are expected to seek and use such medical service as may be required from a physician. If any listed above contraindications are present, client will not receive colon hydrotherapy session in " Biltmore Wellness Center," and will be asked for a written referral from a medical provider. Please understand that in answering questions, we do not diagnose or prescribe, but offer nutritional information only to help you to cooperate with your doctor in your mutual quest of building good health. In the event you use this information without your doctor's approval, you are prescribing for yourself. This is your constitutional right, but "Biltmore Wellness Center" assumes no responsibility.

I understand the service of Colon Hydrotherapy is not designed to diagnose, treat, or cure any disease or medical condition. I understand Colon Hydrotherapy is a process, not a quick cure, and it is used as **a valuable procedure** for the detoxification process, rejuvenation, and restoration of good colon health. Colon hydrotherapy is not a cure; it is a tool for improving health. "Biltmore Wellness Center" has worked with thousands of clients and delivers noticeable, positive results with Colon hydrotherapy. Our client safety and satisfaction is our number one priority. The atmosphere is comfortable and relaxing. Your professional therapist is there to help you stay as relaxed and comfortable as possible.

I understand multiple sessions, combined with good eating habits and regular exercise, are necessary to achieve optimal results. It is advised before beginning a diet, exercise, or complimentary modality, to discuss it with your physician. The number of colonics you may need depends on your goals, intestinal health, dietary habits, and lifestyle choices. Results of procedures may vary and are subjective. No guarantee will be given or implied with regards to the results, effectiveness, client satisfaction, or the duration of achieved results. **I understand Colon Hydrotherapy it is not a weight-loss program and "Biltmore Wellness Center" makes no promises of any weight lost from the sessions.** Although colon hydrotherapy should not be undertaken solely as a weight loss technique, most clients do report the benefit of some weight loss due to the ridding of excess poundage in the form of accumulated waste. When the colon is clean and able to function efficiently, overall digestion, absorption of nutrients and metabolism improves. Some

nutritional supplements may be offered for additional support in the office for your personal use.

Do not discontinue any medications or supplementation prescribed by your physician.

I understand Colon Hydrotherapy is not a medical procedure and will not be covered by most medical insurances.

Identification: As a new patient, you will be asked to submit a valid driver's license or other form of identification before your first treatment, a copy of which will be kept in your confidential medical file.

Children: If you choose to bring your children with you to your appointment(s), they are to remain with you at all times.

Forms of Payment: *Biltmore Wellness Center L.L.C.* accepts cash, Visa, MasterCard, Discover, American Express, and online Paypal as payment for products and services.

Missed Appointments: All cancellations must be made 24 hours prior to your appointment. A $35.00 charge for all cancellations or rescheduling will be made on the day of the appointment.

Prepayment of Service: Any prepayment to secure special pricing is due in full prior to the stated expiration of the special. Payment for service is due at the time of scheduling.

Coupons and Discounts: Coupons must be presented at the time of service to receive any advertised discount. If coupon is not presented for any reason, the full price will be charged. Coupons are not valid after the expiration date listed and may not be used in conjunction with other specials, discounts, or credits. If paid in advance as part of a series, appointments MUST be used within 30 days of purchase (Non Transferable).

Retail Return Policy: All supplements and other retail sales are final.

Refunds and Credits: Payment for services rendered is non-refundable. Results of procedures may vary and are subjective, and no guarantee will be given or implied with regards to the results, effectiveness, client satisfaction or duration of the achieved results.

Property: All personal property must be kept with the client at all times. "Biltmore Wellness Center" is not responsible for lost or stolen items.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND I UNDERSTAND AND AGREE TO ALL PAYMENT AND OFFICE POLICIES.

Signature_____ Date _____

INTAKE FORM AND HEALTH CONSENT FORM

PLEASE READ AND CIRCLE YOUR ANSWER:

Are you a member of the American Medical Association?	YES	NO
Are you a member of the_____ Medical Association?	YES	NO
Are you employed by the Department of Consumer Affairs?	YES	NO
Are you employed by the board of Medical Quality Assurance?	YES	NO

If you are a federal, state, or local agent, upon entering these premises, you must declare the same under the Bivens Act- Article 42 and be held personally and individually liable.

I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENT AND I HAVE TRUTHFULLY ANSWERED THE ABOVE QUESTIONS.

CLIENT'S SIGNATURE:_____ DATE:_____