Health Questionnaire

COLON HYDROTHERAPY/ColoLAVAGE INTAKE FORM

Please complete all pages ~ Please Print

Name: _____ M [ ] F [ ] Birth date ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Height: _____Weight: _____ Marital Status: S [ ] M [ ] D [ ] W [ ] # children: ____ age(s): _____

Home # ( ) _____ Work # ( ) _____ Cell # ( ) _____

Email address: _____ May we contact you at this address? **Y N**

Emergency Contact: _____ Phone: _____

Doctor's name: _____ Telephone: ( ) _____

Are you pregnant? _____ Childbirth History: _____ Blood Type: _____

Medical care: Date of most recent visit to a Primary Care Physician? _____

Are you currently receiving healthcare by a MD/ND/Homeopathic doctor(s)? _____

If so, please explain: _____

Is Colon Hydrotherapy part of a protocol that a doctor or healthcare professional has referred or prescribed for you?

_____

Doctor's name: _____ When? _____

Have you been seen by any specialists such as gastrointestinal doctor, proctologist, etc.? _____

Doctor's name: _____ When? _____

Why? _____

Outcome: _____

List all medications & supplements you now take regularly (including over the counter) _____

_____

(Use back of form if you need more space.)

List all known allergies: _____

Top health concerns: _____

Any surgeries in your abdominal area including Gallbladder, Hysterectomy, C-Section, Vaginal Mesh, Gastric Bypass, Lap Band, Other: _____

If yes to any of the above, do you feel that you have had a change in bowel habits? _____

Health Questionnaire

Colonic History: Have you ever had a colonic before? _____ If so, when? _____

Type of device used (Colonic system) circle all that apply: Closed Open Gravity Not sure

If yes, please describe your experience: _____

Other forms of cleansing you are using or have used: _____

Digestion: How is your digestion? Check one or more of the following:

Adequate_____ Poor _____ Acid reflux _____ Bloating _____ Burning/pain in stomach _____ Other _____

Other complaints: _____

If yes, have you been seen by a doctor? _____

Bowel Habits

How often do your bowels move? 1 time per day_____ 2 times a day_____ 3 times a day_____ Skip days_____

When? Only after eating _____ requires straining _____ effortless _____varies_____

How are your bowel eliminations normally? Circle all that apply

Amount: normal too little too large **Consistency:** normal too hard very soft diarrhea

Color: brown black whitish greenish. **Other**: lots of mucus lots of gas foul smell

Do you feeling your bowel movements are incomplete? YES or NO (please circle)

Do you use: a stool softener _____ laxative _____ suppository _____ enema bag_____

If yes, how often? _____ Product name(s): _____

If yes, used for how long (days, months, years)? _____

Do you have hemorrhoids or other rectal problems (itching, fissures, etc.)? _____

Have you ever had rectal bleeding? _____ If yes, when? _____

If yes, have you been seen by a doctor? _____

Exercise:

Type of exercise	Frequency	Duration

Energy: Please rate your normal energy level on a scale from 1-10: _____

(10 = "optimal energy "- 1 = "can't get out of bed")

Health Questionnaire

Diet: What type of diet best describes your general dietary habits? **Circle best response**: [junk food/fast food eater] [combination (from junk food to health conscious)] [vegetarian] [vegan raw] [health conscious] [natural food eater (over 50% organic)]

How many servings of fruit do you eat per day? _____

How many servings of vegetables do you eat per day? _____ Raw _____ Cooked_____

How much dairy do you consume? _____ How often do you eat meat? _____

Water: How much water do you drink per day? _____ Glasses or _____Ounces _____

Water Source: _____ tap (from city or well) _____ bottled _____ filtered _____ boiled_____

Smoking: Do you currently smoke? _____ If yes, how much? _____ How long? _____

Alcohol Consumption: What kind: _____ Frequency: _____

Stress: Please rate your current stress level (on a scale of 1 to 10, 10 being the highest stress): _____

What are the main sources of your stress? _____

If over level 5, what step(s) are you taking to reduce your stress level? _____

Considering exercise, diet, water intake, and stress; do you notice changes in your bowel habits when you make any changes to any of these? _____ if so, please explain: _____

For Women pre-menopausal:
Monthly cycle: Experience PMS? _____ Are your periods more than 6 days? _____

Please put an **"X"** beside anything that is **currently a health challenge** and a **"P"** beside a **past** problem.

	Abdominal Hernia		Cysts/Tumors		Implants
	Acid reflux		Diabetes		Indigestion
	Allergies		Diarrhea		Infections
	Anemia: Severe		Difficult menstruation		Irritability
	Aneurysm/Blood clots		*Diverticulitis: Acute*		Irritable Bowel Syndrome
	Antibiotic use		Dizziness		*Kidney Dialysis*
	Arthritis		Enlarged Prostate (Males)		Parasites
	Asthma		*Epilepsy/Seizures*		*Pregnancy ~ Current*
	Back aches		Fatigue		*Prostatitis*
	Belching		*Fissure/Fistula*		Psyche disorders
	Birth control pills		Flatulence/gas		Recent Abdominal Surgery
	Blood pressure, Low		Gall bladder		*Renal Insufficiency/Failure*
	Breast implants		*GI Perforation/Hemorrhage*		Severe Anemia
	Cancer (Rectum/Large Intestine		Headaches		Sinus problems
	Cardiac Disease		Hemorrhoids Bleeding		*Surgery: Recent Abdominal*
	Cirrhosis of the Liver		Hepatitis		Swollen glands
	Colitis: Ischemic/Ulcerative		*Hernia: Incarcerated Abdominal*		Ulcers
	Colon or rectal Cancer		Herpes		Uncontrolled Hypertension
	Colon or Rectal Surgery		Hiatal hernia		Urination problems
	Congestive Heart Failure		Hypertension, High BP		Vision problems
	Constipation		Hypoglycemia		Water retention
	Crohn's Disease		Impaired hearing		Yeast infections

Health Questionnaire

Please Circle: "Y" for yes, **"N"** for no and **"S"** for sometimes**. Please list amount and frequency.**

Y	N	S	Alcohol	
Y	N	S	Carbonated drinks	Reg. Diet
Y	N	S	Coffee (circle)	Reg. Decaf.
Y	N	S	Dairy products (type) how often?	
Y	N	S	Diet programs	
Y	N	S	Exercise (type/frequency)	
Y	N	S	Problem sleeping (list hours)	
Y	N	S	Source of water	Bottle Tap Well Spring
Y	N	S	Stress management (type)	
Y	N	S	Sugar/salt cravings	
Y	N	S	Tea (circle)	Reg. Organic
Y	N	S	Tobacco	
Y	N	S	Vegetarian/vegan	

Any Family history of Digestive problems, Cancer, Heart Disease? _____

What do you hope to achieve from this appointment? _____

Do you have a prescription for this visit? _____ On file? _____ Date: _____

How Did You Learn About Our Services?

Personal Referral ____ Doctor/Practitioner _____ Print Ad _____ Internet _____ Yellow Pages _____ Other _____

Who May We Thank for the Referral? Name: _____

Address include City and Zip (if known):_____

I have read this informed consent and understand it. I am not a minor (under the age of 18).

I understand the Financial & Cancellation Policy and will abide by these charges.

I am signing this release voluntarily.

_____

Client Name (Printed)

_____

Client Name (Signature) Date

_____

Therapist Signature (I have reviewed with client) Date

48 Public Square
Mount Vernon, OH 43050
740-392-3377
beth@gentlewaters.org
www.gentlewaters.org

GENTLE WATERS

INFORMED CONSENT AGREEMENT

THE STATE OF OHIO HAS NOT ADOPTED ANY UNIFORM EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED PRACTITIONERS OF COMPLEMENTARY AND ALTERNATIVE MODALITIES. THIS STATEMENT IS FOR INFORMATIONAL PURPOSES ONLY SO THAT CLIENTS OF COLON HYDROTHERAPY AND COLOLAVAGE ARE INFORMED.

It is understood that the colon hydrotherapist BETH SEEMANN makes no claims to cure or treat any medical conditions nor does she diagnose or prescribe any medications. She is certified to provide colon hydrotherapy and ColoLAVAGE by The Global Professional Association for Colon Therapy, Member # CT-00091. Complaints may be filed with this organization www.gpact.org.

The undersigned client agrees to seek competent medical or other professional services for conditions that require such counsel. He/She has been provided with a MEDICAL RELEASE FORM to be signed by their doctor prior to any treatments in order to be cleared for contraindications.

Description of therapy: colon hydrotherapy and/or ColoLAVAGE

I acknowledge that (client name) _____ has voluntarily contacted me for colon hydrotherapy and/or ColoLAVAGE and state clearly that the dialogue between us is strictly confidential unless written permission is given to share records with other health care professionals.

Client Name (Printed)

Client Signature Date

Therapist Signature Date

48 Public Square
Mount Vernon, OH 43050
740-392-3377
beth@gentlewaters.org
www.gentlewaters.org

GENTLE WATERS

CONTRACT FOR SERVICES WITH GENTLE WATERS, LLC

The services and educational information that I receive from Gentle Waters are to enhance and/or maintain my physical, emotional, and spiritual wellness. I also understand that the Gentle Waters staff are natural wellness practitioners, **not medical doctors** and they **do not practice medicine** in this office.

The services of Gentle Waters are provided for the cleansing of the colon through colon hydrotherapy and/or ColoLAVAGE. Ionic Foot Spa, BACH Flowers and Ear Candling are also available.

I am personally responsible for obtaining qualified medical assistance for the treatment of any disease or pathological condition(s) that I now have or may develop in the future.

PRIVACY POLICY

It is the policy of Gentle Waters that all client records, conversations, messages, faxed documents, test results, testing procedures and treatment modalities shall be maintained in a strictly confidential manner, guarded in the strictest manner consistent with professional ethics, dignity and privacy of each and every individual.

The client is to be made aware that his/her treatment record, as generated within the facility of Gentle Waters is to be made available for private viewing by said client within the facility premises, upon a timely manner, but not to interrupt the normal operations of the facility.

These records may not be viewed by any other individual without the client's written consent. Copies of any and all documents within the client's record may be made at the expense of the client, but the client record may not be removed from the facility, except under subpoena.

I, the undersigned client, understand this information.

Client Printed Name

Client Signature Date

Therapist Signature Date

48 Public Square
Mount Vernon, OH 43050
740-392-3377
beth@gentlewaters.org
www.gentlewaters.org

GENTLE WATERS

FINANCIAL, CANCELLATION POLICY, AND RELEASE STATEMENT

Colon Hydrotherapy Initial Session (1 ½ -2hrs)	$ 120
Single Session	$ 90
Package of 3 Colon Hydrotherapy Sessions (Pre-paid)	**$ 305**
ColoLAVAGE	**$ 90**
Ear Candling includes 4 candles (extra candles are $3)	$ 38
Ionic Foot Detox (1 hour)	$ 38
Chi Machine (energy alignment)	$ 20
BACH Flowers	$ 25
Returned checks charge	$ 30
Appointments Not Cancelled 6 hours prior to appt.	**Half the cost of service requested**
No Show for appt.	**100% of scheduled service**

An initial appointment includes a consultation and colon hydrotherapy session will take approximately 1½ - 2 hours. Follow up sessions last approximately 1 ½ hours. There may be supplements recommended to complement and enhance the process of cleansing, and rebalancing the system. These supplements are an additional cost. **All payments are due at the time of visit. We accept payments in cash, checks, and credit cards with a 3% convenience fee. Packages must be used within 6 months from the time of purchase.** There may be times when promotional prices are offered. **Only one discount can be used at a time.**
Prices are subject to change without notice.

Your time is valuable and we appreciate your understanding that our time is valuable as well. In the event you need to cancel an appointment, and as a courtesy to your therapist, please provide at least six (6) hours notification (24 hours is preferable). **Appointments not cancelled six (6) hours prior to your appointment time will be subject to a 50% charge of your session price. No show appointments will be charged 100% of session price.** THIS PAYMENT MUST BE MADE BEFORE ANY SUBSEQUENT SERVICES WILL BE PROVIDED.

PACKAGES: **All packages are non-refundable and have no cash value**. They cannot be used with any other offers and are not transferable. If at any time prior to your final payment you choose not to continue your sessions, you will be responsible for the remainder of your balance. IF YOU FAIL TO SHOW UP FOR YOUR SCHEDULED APPOINTMENT YOU WILL FORFEIT THAT SESSION.

I acknowledge that Gentle Waters and all staff members are NOT medical doctors. I understand that Beth Seemann and staff members of Gentle Waters may provide nutritional and other health related information to help me attain and maintain my best health. All suggestions are designed to help me move towards my best state of health through personalized recommendations in lifestyle, exercise, health habits, and advanced nutrition. I understand that Beth Seemann as well as staff members of Gentle Waters do NOT diagnose, treat or claim to cure any illness or disease. The services of Gentle Waters are provided for the cleansing of the colon through colon hydrotherapy, pre-colonoscopy preps, and others. I am responsible for obtaining qualified medical assistance for the treatment of any disease or pathological condition(s) that I now have or may develop in the future.

I have been made aware of all contraindications for colon hydrotherapy and ColoLAVAGE and am here on this day and any subsequent visits by my choice and solely on my own behalf. I hereby release and discharge Beth Seemann, Gentle Waters, from any and all claims which I or my agents ever had, now have, or may have relating to or arising out of services provided or recommendations that I have received. I acknowledge that it is my responsibility to consult with my physician or other health care providers relating to any disease or condition that I may have.

I have read this informed consent and understand it. I am not a minor (under the age of 18). By signing this agreement, I have read and understand the above policy regarding pricing, package pricing, and payment terms. Furthermore, I understand that if I do not show for an appointment I am responsible for 100% of the session cost, if the appt. is part of a package I understand that session will be forfeited. I am signing this release voluntarily.

_____

Client Name (Printed) Client Name (Signature) Date

_____

Therapist (Signature) I have reviewed this form with above client. Date

Rev. 10/2016