**Holistic Questioner**

**FULL NAME­­­­­­­­­­­­­­­­­­:** Click here to enter text. **DATE:** Click here to enter text.

**ADDRESS:** Click here to enter text. **CITY:** Click here to enter  **STATE: \_\_\_\_\_\_ ZIP:** Click here to enter text.

**PHONE (Home):** Click here to enter text. **(Cell):** Click here to enter text.

**(E-MAIL):** Click here to enter text. **OCCUPATION:** Click here to enter text.

**DATE OF BIRTH:** Click here to enter text. **WEIGHT:** Click here to enter text.

**EVER HAD A COLON HYDROTHERAPY BEFORE?** Click here to enter text. **IF SO'WHEN?\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOW DID YOU LEARN OF OUR SERVICES?** Click here to enter text.

**ARE YOU NOW UINDER A DOCTOR'S CARE?** Click here to enter text. **IF SO PLEASEEXPLAIN:** Click here to enter text. **MAJOR PHISICALCOMPLAINTS:** Click here to enter text.

**LIST ALL MEDICATIONS & SUPPLEMENTS YOU NOW TAKE REGULARLY (INCLUDING OVER’ THECOUNTER)** Click here to enter text.

**LIST ALL KNOWN ALLERGIES:** Click here to enter text.

**HOW MANY BOWEL MOVEMENTS PER DAY DO YOU USUALLY HAVE?** Click here to enter text.

**DO YOU HAVE TO STRAIN TO HAVE A BOWEL MOVEMENT?** Click here to enter text.

**DO YOU USE A STOOL SOFTENER OR LAXATIVE?** Click here to enter text.

**HERBAL LAXATIVE?** Click here to enter text.

**DO YOU HAVE HEMMORHOIDS OR OTHER RECTALPROBLEMS?** Click here to enter text.

**HAVE YOU EVER HAD A BARIUM ENEMA?** Click here to enter text. **IFSO, WHEN?** Click here to enter ext.

**WHAT WOULD YOU LIKE TO RECETVE FR.OM THIS APPOINTMENT?** Click here to enter text.

**SIGNATURE:** Click here to enter text. **(PRINT) (Continue to next page)**

**CHECK (“C”) FOR CURRENT CONDITION**

**CHECK (“P”) FOR PAST CONDITION**

**INTELCTUAL** **CENTER** **“C”**   **“P”** **WORLD** **CENTER** **“C”** **“P”**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Blurred vision |  |  | Sigh frequently, “ air hunger” |  |  |
| Falling hair excessive |  |  | Perspire easily |  |  |
| Eat when nervous |  |  | Pressure in pit of stomach |  |  |
| Bitter, metallic taste in mouth in morning |  |  | Extremities cold ,clammy |  |  |
| Dry mouth, eyes, nose |  |  | Heart pounds after retiring |  |  |
| Eyelids swollen, puffy |  |  | Hands and feet go to sleep easily , numbness |  |  |
| Eyes or nose watery |  |  | Greasy food upset |  |  |
| Difficulty remembering |  |  | Pain between shoulder blades |  |  |
| Sneezing attacks |  |  |  |  |  |
| Moods of depression |  |  | History of gall bladder problems |  |  |
| Worried , feel insecure |  |  | Overeating sweet upset |  |  |
| Irritable before meals |  |  | History of gallstones |  |  |
| Faintness when meals delayed |  |  | Acid foods upset |  |  |
| Coated tongue |  |  | Indigestion ½ to 1 hour after meals, or up to 3-4 hours later |  |  |
| Can’t get thought out of head |  |  | Waken after few hours’ sleep ;hard to get back to sleep |  |  |
| Frequent nosebleeds |  |  | Hoarseness frequent |  |  |
| Nightmare-type bed dreams |  |  | Breathing irregular |  |  |
| Noises in head or ears |  |  | Difficulty swallowing |  |  |
| Keyed up |  |  | Milk products distress |  |  |
| Susceptible to colds |  |  | Dull pain in chest and left arm |  |  |
| Afternoon headaches |  |  | Stomach “bloating” after meals |  |  |
| Get drowsy often |  |  | Sour stomach frequent |  |  |
| Can’t get to sleep |  |  | Circulation poor |  |  |
| Bad breath (halitosis) |  |  | Tension under ribcage |  |  |
| Crave candy or coffee |  |  | Pulse speeds after meal |  |  |
| Fever easily raised |  |  | Digestion difficult |  |  |
| **GROUNDING CENTER** |  |  | “Butterfly” stomach, cramps |  |  |
| Burning Feet |  |  | Indigestion soon after meals |  |  |
| Itching skin and feet |  |  | Aware of “breathing heavily” |  |  |
| Bowel movements painful and difficult |  |  | Biliousness |  |  |
| Loss of leg energy |  |  | Heart palpitates if meals missed or delayed |  |  |
| Muscle / leg/ toe cramps at night |  |  | Constipation / diarrhea alternating |  |  |
| Swollen ankles |  |  | Mucous colitis |  |  |
| Lower bowel gas a few hours after eating |  |  | “ Nervous “ stomach |  |  |
| Skin peels of feet |  |  | Susceptible to colds, asthma, bronchitis |  |  |
| Stools alternate soft /watery |  |  | Stools light in color |  |  |
| Urine amount reduced |  |  | Sensitive to hot weather |  |  |
| Muscle cramps, worse during exercise, get “ charley horses” |  |  | Lose taste for meals |  |  |
| Frequent urination |  |  | Excessive appetite |  |  |
| Stool has foul odor |  |  | Get “shaky” if hungry |  |  |
| Burning or itching anus |  |  | Vomiting frequently |  |  |
| **MISCELLANEOUS** |  |  | Pulse slow ,irregular |  |  |
| Dizziness |  |  | Gay easily |  |  |
| Dry skin |  |  | Shortness of breath |  |  |
| Skin rashes frequent |  |  | Gas shortly after eating |  |  |
| Hungry between meals |  |  | Appetite reduced |  |  |
| Fatigue ,relieved by eating |  |  | Neuralgia-like pain |  |  |
| Joint stiffness after arising |  |  |  |  |  |
| Open windows in closed room |  |  |  |  |  |
| Laxative used often |  |  |  |  |  |
| Strong light irritates |  |  |  |  |  |
| Cold sweats often |  |  |  |  |  |
| Bruise easily ; “ black and blue “ spots |  |  |  |  |  |
| Burning stomach sensation |  |  |  |  |  |

**CONSENT FORM**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(**PRINT YOUR NAME**)hereby request and consent to the performance of colon hydrotherapy and other related procedure on me (or on the person named below, for whom I am legally responsible) by the colon hydrotherapist indicated below and/or other colon hydrotherapists who now or in the future treat me while employed by, working or associated with or serving as back-up for the colon hydrotherapist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that the attending therapist is not an allopathic doctor, but has been trained as a certified colon hydrotherapist. I fully understand that the attending therapist cannot diagnose, or prescribe and does not offer allopathic drugs, surgery, or chemical stimulants, or radiation therapy. I understand that illness is not being diagnosed, nor treated, or cured and no representation of such is being expressed or implied.

I understand that methods of treatment may include, but not limited to, the use of a colon hydrotherapy machine to put water into and out of my colon and to remove whatever is in my colon. I understand it is my responsibility to communicate with my therapist during the session.

I have been informed that colon hydrotherapy is a generally safe procedure. I do not expect the staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the staff to exercise judgment during the course of the procedure which the staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent, have been told about colon hydrotherapy and procedures, and I have had an opportunity to ask questions. I intend this consent form to cover the entire course of procedures and for any future procedures I receive.

I have solicited the attending therapist’s services in good faith, exercising my free will and following the dictates of my own conscience which allows me to select what therapies I choose for my health.

I hereby release the colon hydrotherapist to assist me with my colon hydrotherapy session(s). In addition, I further release *Hamri’s Health & Wellness, LLC*, the owner(s), and their employees of any liability associated with therapies that I have solicited while at *Hamri’s Health & Wellness, LLC*.

\_\_\_\_\_ (INITIAL) **Cancellation Policy:** I understand appointments cancelled in less than 24 hours’ notice is subject to cancellation fee. Missed appointments are billed at the regular rate.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print for e-signature)