InnerBliss
REJUVENATION CENTER

HOLISTIC QUESTIONNAIRE

Name _____ Male/Female _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Phone (home) _____ (cell) _____ (work) _____

Email _____ Occupation _____ DOB _____

Height _____ Weight _____ Blood Type _____ Marital Status _____

Do you have any children? ❑ YES ❑ NO If so how many? _____

Ever had a colonic before? ❑ YES ❑ NO If so, when? _____

Other forms of cleanse? _____

How did you hear of our services? _____ If online please specify _____

Are you under a doctors care? ❑ YES ❑ NO _____ If so, please explain _____

List all major physical complaints _____

List all surgeries and date conducted _____

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

_____

List all supplements you now take regularly (vitamins, minerals, herbs, superfoods, etc.) _____

_____

List all known allergies _____

How many bowel movements per day do you usually have? _____

Do you strain or have pain when having a bowel movement? _____

Do you use a stool softener, laxative, or suppository? _____ What type? _____

Do you have hemorrhoids or other rectal problems? _____

Have you had any rectal bleeding? ❑ YES ❑ NO If so, when? Bleeding currently?

Have you ever had a barium enema? ❑ YES ❑ NO If so, when? Results? _____

_____

How often do you consume the following items?

Dairy (milk, ice cream, cheese, yogurt, etc.):

daily _____ weekly _____ monthly _____ rarely _____ never _____

Red meat: daily _____ weekly _____ monthly _____ rarely _____ never _____

Chicken: daily _____ weekly _____ monthly _____ rarely _____ never

Fish: daily _____ weekly _____ monthly _____ rarely _____ never _____

Refined flour (pasta, bread, cookies, bagels, crackers, etc.):

daily_____ weekly_____ monthly _____ rarely_____ never _____

Soda: daily _____ weekly_____ monthly _____ rarely_____ never _____

Coffee/Tea (please specify) _____:

daily_____ weekly_____ monthly _____ rarely_____ never _____

Vegetables: daily_____ weekly_____ monthly _____ rarely_____ never _____

Fresh fruits: daily_____ weekly_____ monthly _____ rarely_____ never _____

Whole grains: daily _____ weekly_____ monthly _____ rarely_____ never _____

How many alcoholic beverages do you consume per week?_____

How many 8 oz. Glasses of water do you drink per day?_____

Do you exercise regularly?: ❑ YES ❑ NO

IF YES: How many days a week do you exercise?: _____

What types of exercise do you enjoy?: _____

Please circle any of the following health conditions that apply to you:

Cirrhosis	severe hypertension	pregnancy	aneurysm
severe anemia	abdominal hernia	severe hemorrhoids	colon cancer
Gi hemorrhage/perforation		renal insufficiency	fissures/fistulas
		recent colon surgery (less than 3 months)	

WOMEN ONLY:

Are your periods regular? _____Do you experience pms? _____ Cramping? _____

Are you pregnant? _____If so, what trimester? _____

Do you experience yeast infections? _____How often? _____

PATIENT PRIVACY POLICY

We at Inner Bliss Rejuvenation Center pledge to give you the highest quality health care and to have a Relationship with you that is built on trust. This trust includes our commitment to respect the Privacy and confidentiality of your health information.

INNER BLISS DISCLAIMER TERMS OF TREATMENT

(*Please read and initial the following three statements.)*

We understand that circumstances can and do occasionally arise which would make you unable to attend a scheduled appointment. To prevent any late cancellation charges, our policy requires that you give us 24 hours notice of any cancellation, at which time we would be happy to reschedule your appointment. If less than 24 hours is given, you will be required to pay the full amount of the missed appointment. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment at the time of the appointment. We do not refund any packages purchased, unless it is medically necessary by your physician with a written script.

Thank you for your cooperation

I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder and does not prescribe medical treatment or pharmaceuticals .It has been made clear to me that colon hydrotherapy is not a cure or substitute for medical examination or diagnosis and that it is recommended that I see a physician for any ailments that I might have. I acknowledge that I have fully and honestly disclosed my health history to the therapist. I agree that the therapist is helping me with natural hygiene at my request, and is not diagnosing, nor treating disease, nor practicing any form of medicine. I clearly hereby approve that the colon hydro-therapist can touch me as is required for the procedure.

*Signature:*_____ *Date:* _____