Natural Pure Living

FAX: 310.362.8403
heather@naturalpureliving.com

CLIENT INFORMATION

TODAY'S DATE: _____/_____/_____

LAST NAME: _____

FIRST NAME: _____

PARENT | GUARDIAN OF CLIENT?
_____

NAME AND RELATIONSHIP TO CLIENT:
_____

ADDRESS:_____

CITY, ZIP: _____

EMAIL:_____
DATE OF BIRTH: _____/_____/_____
PRIMARY NUMBER: _____ HOME: _____ CELL/ALTERNATE:_____
WORK: _____
EMAIL: _____

REFERRED BY (SPECIFY)
NAME: _____

What health conditions are you currently being treated for and by whom?
_____
_____

Have you ever had colonics? _____
If so, how many?_____ When? _____

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A Contraindication is any indication or symptom that makes it inadvisable to use a particular therapy. The following are contraindications for colon hydrotherapy. If any of these apply to you we are not able to provide you with colon hydrotherapy at this present time. If you have any of these contraindications you may still be eligible to receive colon hydrotherapy once they have subsided or been eliminated or if you are under the order, guidance and supervision of a qualified physician working with us.

Please put an "X" in the appropriate box. If you have a prescription from a doctor showing supervision over services provided by us, please check the box to the right of that condition.

YES	NO	CONDITION	PRESCRIPTION
		Colon Cancer or GI tract	
		Acute Abdominal Pain	
		History of rectal bleeding	
		Congestive Heart Failure	
		Uncontrolled Hypertension	
		History of Seizures	
		Carcinoma of the rectum	
		Abdominal surgery	
		Intestinal perforation	
		Abdominal hernia	
		Colon or rectal surgery	
		Diverticulitis	
		Recent heart attack	
		General dibilitation	
		Vascular aneurism	
		Renal insufficiency	
		Epilepsy or psychoses	
		Severe hemorrhoids	
		Cirrhosis	
		Fissures or fistula	
		Pregnancy	
		Ulcerative colitis	
		Acute Crohn's disease	
		Rectal or abdominal tumors	

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PLEASE CIRCLE ALL THAT APPLY

GENERAL	MUSCLE & JOINT	GASTRO INTERNAL	CARDIOVASCULAR
Anxiety	Arthritis	Constipation	High Blood Pressure
Agorophobia	Bursitis	Diarrhea	Hardening of the Arteries
Back Pain	Low Back Pain	Spastic colon	Angina (Chest pain)
Brain Fog	Neck Pain	Gas, bloating	Poor Circulation
Chemical Sensitivity	Other Joints	Candida	Rapid heart beat
Depression		Parasites	
Depersonalization (Feeling numb)	GENITO-URINARY	Excessive belching	WOMEN
Derealization (Fish Bowl)	Kidney infection or stones	Heart Burn	Painful menstruation
Dizziness Fatigue Brain Zaps	Painful urination	I.B.S | Irritable Bowel Syndrome |	Date of last menstral cycle __/__/__ Is it heavy? YES | NO
Double Vision			Vaginal Discharge
Fanting Spells			Breast Pain
Fatigue/Exhaustion Voice Echo Detached feeling			Are you pregnant? YES | NO
Fibromyalgia			
Panic Attacks how many ____ when ____	RESPIRATORY		SKIN
Headaches	Shortness of Breath		Bruise easily
Insomnia	Chronic Cough		Dryness
Metal Toxicity	Heavy mucus production		Itching
Night Sweats	Emphysema		Rash
Feelings of Vertigo	Bronchitis		Acne
Weight issues	Asthma		Psoriasis
Social Phobia			
Other Phobias			

BOWEL RELATED INFORMATION					
How many bowel movements a day or a week (on average) do you have?					
Are you now, or any possibility of being pregnant?	YES	NO			
Are you breastfeeding?	YES	NO			
Do you have pain in areas of your abdomien or bowel?	YES	NO			
Any abdominal surgeries or pregnancies?	YES	NO	What type	How many	When

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PLEASE DESCRIBE YOUR HISTORICAL USE OF THE FOLLOWING
Antibiotics
Birth Control
Chemical Laxatives
Tobacco
Coffee
Pharmaceutical aid/or recreational drugs

NUTRITION & LIFESTYLE

Do you buy organically grown fruits and vegetables? YES | NO Dairy and Meat YES | NO

Do you follow a special diet? YES | NO

If yes, how would you describe the diet? (ie. Raw food, Vegan, Vegetarian, Low Carb, Gluten Free, Paleo Diet etc)

_____

_____

What do you eat on a "typical" day?

Breakfast_____

_____

Lunch_____

_____

Dinner_____

_____

Snacks:_____

_____

Foods you tend to crave:

_____

_____

Foods you dislike:

_____

_____

DESCRIBE YOUR DAILY LIQUID INTAKE IN OUNCES			
Water (filtered?)	Soda	Herbal Tea	Alcohol
Juice	Coffee	Black Tea	Other

ALLERGIES (to medications, chemicals or foods):

_____

_____

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Do you have any known nutritional deficiencies:?

Describe your exercise habits:

Other types of body work you receive:

Rate on a scale of 1 - 10 the stress in your life: 1 2 3 4 5 6 7 8 9 10

Are you currently taking any supplements? (Vitamins, minerals, fiber, friendly bacteria, digestive support or other?

GOALS: What would you most like to achieve through your work?

MAJOR SYMPTOMS: Please list in order of importance what symptoms are of concern to you. (most concerning to least, along with the duration of the symptom)

SURGICAL HISTORY (Please list any surgical procedure and dates)

SOCIAL HISTORY

Do you have a known history of any exposure to toxic substances? YES | NO

If so, please list which and when you first noticed symptoms?

In the past year, how many days have been significantly affected by your health? _____

How many days/years did you generally feel poor? _____

How many times were you in the hospital? _____

How many hours of sleep do you usually get per night during the week? _____

Do you awake feeling rested? YES | NO

Do you feel you sleep well at night? YES | NO

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AMENDMENT IX, U.S. CONSITUTION

"The enumeration in the Consitution, of certain rights, shall be construed to deny or disparage others retained by the People."

Protected against governmental infringement through the Ninth Amendment to the Consitution of the United States of America, I retain the right to receive education and information of any nature related to this transmittal and to act upon the information in any way I see fit. In its acceptance, as is my right and duty, I assume full responsibility for its application if acted upon.

CONSTRUCTIVE NOTICE

Notice is hereby given to any person who receives a copy of this transmittal and who, acting under the color of law intentionally interferes with the free exercse of the rights retained by me as enumerated herein, that he may be in violation of my civil and consitutionally protected rights, Title 42, U.S.C. 1983 seq. and Title 18, Section 241.

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, substitute for medical examination or diagnoses and it is recommended that I see a physician for any ailments I might have. 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.

Natural Pure Living is a private wellness club, of which I agree to membership by-laws, which include the bove amendment and constructive notice. For a copy of all membership considerations as well as a primer in your consitutional rights, please ask for a full packet.

Signed:	Dated: