



7501 Murdoch Avenue
Shrewsbury, MO 63119
314-647-3999
www.holifit.com

CONFIDENTIAL PATIENT CASE HISTORY HYDROTHERAPY CONSULT

NAME _____ DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____

CELL PHONE (_____) _____

WORK PHONE (_____) _____

EMAIL _____

DATE OF BIRTH _____ AGE _____ M _____ F _____

OCCUPATION _____ REFERRED BY _____

WHAT IS YOUR MAJOR COMPLAINT? _____

HOW LONG HAVE YOU HAD THIS CONDITION? _____

HOW OFTEN DO YOU HAVE BOWEL MOVEMENTS? _____

NAME OF CURRENT PHYSICIAN _____

LIST ANY SURGICAL PROCEDURES YOU HAVE HAD _____

LIST ANY MEDICAL CONDITIONS FOR WHICH YOU ARE CURRENTLY BEING TREATED, OR HAVE BEEN TREATED FOR IN THE PAST FIVE YEARS _____

LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING AND FOR WHAT CONDITIONS THEY HAVE BEEN PRESCRIBED _____

FAMILY HEALTH INFORMATION

RELATIONSHIP PREVIOUS/PRESENT HEALTH PROBLEMS _____

DESCRIBE YOUR DIET _____

HOW MUCH WATER DO YOU DRINK? _____

DO YOU EXERCISE? IF SO, WHAT KIND AND HOW OFTEN? _____

DO YOU HAVE ANY KNOWN DRUG ALLERGIES? _____

HABITS:	HEAVY	MODERATE	LIGHT	NONE
ALCOHOL	_____	_____	_____	_____
COFFEE	_____	_____	_____	_____
TOBACCO	_____	_____	_____	_____
DRUGS	_____	_____	_____	_____
APPETITE	_____	_____	_____	_____



Contra-Indications for receiving Colon Hydrotherapy:

- 1) Severe cardiac disease
- 2) Cirrhosis of the liver
- 3) Aneurysm/Blood clots
- 4) Severe anemia
- 5) GI hemorrhage/Perforations
- 6) Severe hemorrhoids (bleeding or inflamed)
- 7) Pregnancy (except during the second trimester)
- 8) Carcinoma of the colon
- 9) Fissures/Fistulas
- 10) Abdominal hernia
- 11) Colon or abdominal surgery within the last six months
- 12) Renal insufficiency
- 13) Dementia
- 14) Alzheimer's
- 15) Exposure to Agent Orange
- 16) High Blood Pressure requiring medication
- 17) Currently on Anti-Psychotic Medications

Indications Under Prescription or Direct Supervision of a Physician:

- 1) Diverticulitis (active, bleeding or recent hospitalization)
- 2) Ulcerative Colitis
- 3) Crohn's Disease
- 4) Cancer or currently receiving chemotherapy or radiation treatments

By signing this I state that I do not have any of the above conditions.

Signature

Date



CANCELLATION POLICIES

All clients are expected to cancel scheduled appointments at least **24 hours prior** to their scheduled appointment times. A client who fails to cancel 24 hours prior to his or her appointment, or misses his or her appointment altogether, will be charged the **full fee** for a colonic.

Each client is expected to pay fees in full at the time services are provided. Clients will be charged a \$25.00 fee for returned checks.

A client who purchases a package of 3 or 6 colonics and subsequently requests a refund on the remainder of the package will lose the discounted rate associated with that package. The colonics already provided in that package will revert to the fee per single colonic of \$75 and will be subtracted from the original package price. A \$25 processing fee will be deducted and the client will receive a prompt refund of the remaining balance.

***All packages expire six months from the date of purchase. ***

PLEASE NOTE: WHILE IN MOST CASES WE WILL PROVIDE YOU WITH A COURTESY CALL TO REMIND YOU OF YOUR SCHEDULED APPOINTMENT, WHETHER OR NOT YOU RECEIVE A CALL, YOU ARE STILL RESPONSIBLE FOR YOUR SCHEDULED APPOINTMENT TIME.

By providing my signature below, I understand and agree to all the terms and conditions stated above.

Signature

Date



HOLISTIC FITNESS
CONFIDENTIALITY STATEMENT

We maintain strict client/therapist confidentiality at **Holistic Fitness**. Information discussed in sessions is a private matter. Current law and ethical practice require us to break confidentiality under the following very specific conditions:

1. Law requires that we notify all relevant individuals if we judge that a client has the intention of doing harm to himself/herself or to another individual.
2. Law requires that we report any current or past suspected incidence of child molestation, abuse, or neglect.
3. In all legal cases, the court can subpoena medical records. A representative from our office may be required to testify or verify information contained within the confines of our office or written records.

If there is ever a necessity to break our confidentiality policy, we will make every attempt to notify you beforehand. If you have any questions regarding this statement, please do not hesitate to ask.

I have read the above material and I understand the confidentiality limitations.

Signature

Date