



## Confidential Health Questionnaire

Today's Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Name: \_\_\_\_\_ M \_\_\_ F \_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Occupation: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Marital Status: S \_\_\_ M \_\_\_ D \_\_\_ W \_\_\_ No. of children \_\_\_\_\_

Primary phone: (\_\_\_\_) \_\_\_\_\_ Secondary phone: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

\_\_\_\_\_ Check here if you would like to receive Cleansing Waters E-mail Newsletters.

Have you ever experienced Colon Hydrotherapy or Enemas? \_\_\_\_\_

Why are you requesting Colon Cleansing? \_\_\_\_\_

List your main health concerns and state briefly how long each has been an issue for you:

\_\_\_\_\_  
\_\_\_\_\_

List all medications and/or supplements that you are currently using (please include why you are taking them if possible). Be sure to include non-prescription medications such as aspirin, laxatives, vitamins, minerals, homeopathic, herbs, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What inherent (genetic) health issues run in your family?

\_\_\_\_\_  
\_\_\_\_\_

Are you currently under medical treatment elsewhere for any specific health issue? If so, please list the health issue and the treatment you are undergoing:

\_\_\_\_\_  
\_\_\_\_\_

**Do you currently:**

**Smoke (how much or when did you quit):** \_\_\_\_\_

**Drink Alcohol (how much and how often):** \_\_\_\_\_

**Drink Coffee, Tea, or other caffeinated beverage (how much/day):** \_\_\_\_\_

**Drink Soft drinks (how much/day):** \_\_\_\_\_

**Exercise (what type, how often):** \_\_\_\_\_

**How often do you eat fast food?** \_\_\_\_\_

**How many times a day do you eat poultry, beef or fish products?** \_\_\_\_\_

**How many times a day do you eat dairy (milk, cheese, etc.)?** \_\_\_\_\_

**What percent of Organic food do you eat?** \_\_\_\_\_

**How much water do you drink each day?** \_\_\_\_\_

**Do you use a microwave?** \_\_\_\_\_

**How is your energy throughout the day? (high, average, low)** \_\_\_\_\_

**How many hours of sleep/night?** \_\_\_\_\_

**Do you wake up feeling rested?** \_\_\_\_\_

**Are you at your ideal weight, underweight, or overweight?** \_\_\_\_\_

**If overweight or underweight, how much?** \_\_\_\_\_

**How many bowel movements are you having each day?** \_\_\_\_\_

**Do you experience indigestion, bloating, or are you gassy after meals?** \_\_\_\_\_

**Have you ever done any type of detox or cleanse?** \_\_\_\_\_

**What is your Blood Type?** \_\_\_\_\_

**Are you currently on any special diets or avoid certain foods?** \_\_\_\_\_

**Give an example of an average day of eating, including any snacks:**

**Breakfast:** \_\_\_\_\_

**Lunch:** \_\_\_\_\_

**Dinner:** \_\_\_\_\_

**Snacks:** \_\_\_\_\_

**Desserts:** \_\_\_\_\_

# Digestive Health Self-Tests

## CONSTIPATION:

1. Do you feel fatigued more than you feel energized?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
  2. Do you have 1 bowel movement or less every day?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
  3. Is your stool similar to toothpaste, in consistency?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 0, NO = 1)                      \_\_\_\_\_
  4. Do you experience an abundance of foul smelling gas?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
  5. Are your bowel movements dense and heavy? (plummet to the bottom of the toilet quickly)  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
  6. Do you eat 30-40 grams of fiber per day?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 0, NO = 1)                      \_\_\_\_\_
  7. Are you unable to lose weight even though you eat a "healthy diet"?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
  8. Do you take anti-depressants or pain medication?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
  9. Do you drink 8-10 glasses of water every day?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 0, NO = 1)                      \_\_\_\_\_
  10. Do you exercise at least 3 times per week?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 0, NO = 1)                      \_\_\_\_\_
- (A score of 3 or higher indicates you may be suffering from Constipation)                      **TOTAL SCORE:** \_\_\_\_\_

## IBS:

1. Do you experience abdominal cramping and loose stools, cramping and constipation or alternating diarrhea & constipation?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
  2. Do you have a sense of incomplete evacuation?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
  3. Do you have the passage of mucus in your stool?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
  4. Do you have consistent abdominal bloating?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
  5. Does wheat (pasta, bread, etc.) cause you abdominal cramping that is relieved by a bowel movement?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
  6. Do dairy products cause you abdominal cramping that is relieved by a bowel movement?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
  7. Do fatty foods such as meat, poultry skin, oils or nuts cause you abdominal cramping that is relieved by a bowel movement?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
  8. Does soluble fiber, like psyllium and vegetables like broccoli and cauliflower give you gas and cramping?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
  9. Do you experience diarrhea or constipation after eating artificial sweeteners or sugar alcohols?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
  10. Have you ever experienced Candida or yeast overgrowth (nail fungus, athlete's foot, thrush, vaginal yeast infections)?  
\_\_\_\_\_ YES                      \_\_\_\_\_ NO                      (YES = 1, NO = 0)                      \_\_\_\_\_
- (A score of 3 or higher indicates you may be suffering from IBS)                      **TOTAL SCORE:** \_\_\_\_\_

**CANDIDA:**

- 1. Do you experience regular fatigue and/or muscle aches and pains?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 2. Do you have food sensitivities or food allergies?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 3. Have you experience nail fungus, athlete's foot or jock itch?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 4. Do you have recurrent vaginal yeast infections?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 5. Have you taken broad spectrum antibiotics - even for one period?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 6. Do you crave sugar?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 7. Do you commonly have gas and bloating?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 8. Do you crave bread, pasta, etc. (any type of refined white flour)?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 9. Have you taken birth control pills for 6 months or longer?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 10. Do you experience brain fog?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_

(A score of 3 or higher indicates you may be suffering from Candida)      **TOTAL SCORE:** \_\_\_\_\_

**PARASITES:**

- 1. Do you experience unexplained muscle aches and pains?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 2. Do you experience normal bowel movements with bouts of intermittent diarrhea or constipation?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 3. Do you have unexplained weight loss and/or fever?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 4. Do you have a distended belly?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 5. Do you grind your teeth while you sleep?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 6. Do you have dark circles under your eyes and/or acne?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 7. Do you have insomnia or disturbed sleep?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 8. Have you traveled outside of the United States?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 9. Do you regularly eat unpeeled raw fruit and/or vegetables?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_
- 10. Do you have pets that sleep in bed with you or do you eat after contact with you pets?  
 YES       NO      (YES = 1, NO = 0)      \_\_\_\_\_

(A score of 3 or higher indicates you may be suffering from Parasites)      **TOTAL SCORE:** \_\_\_\_\_

Please take your time and check all symptoms you have had in the past year. Be as thorough as possible.  
Your Health History is Confidential. Please list anything that is not on this list.

### General Symptoms

- Allergies
- Colds
- Depression
- Dizziness
- Fatigue
- Fainting Spells
- Frequent Headaches
- Sweats
- Insomnia
- Nervousness
- Overweight
- Underweight
- Flu
- Fever

### Eyes, Ears, Nose, Throat

- Double/blurred vision
- Earache
- Ears Ringing / Itching
- Fever blisters
- Gum trouble
- Hay Fever
- Lymph Glands enlarged
- Nose bleeds
- Sinus Infections
- Sore throat
- Thyroid enlarged
- Nasal Drainage
- Eye Pain

### Skin

- Acne
- Boils
- Bruise easily
- Dryness
- Hives
- Eczema
- Sensitive Skin
- Skin Eruptions
- Skin Rash
- Psoriasis
- Varicose Veins
- Bumps on back of arms
- Itching

### Genito-Urinary

- Bladder trouble
- Control of urine
- Frequent Urination
- Kidney Failure
- Kidney Infection / Pain
- Kidney Stones
- Painful Urination
- Prostate trouble

### Joints/Bones/Muscles

- Arthritis
- Back Pain
- Bursitis
- Joint Pain
- Neck Pain
- Sciatica
- Osteoporosis

### Cardio-Vascular

- High Blood Pressure
- Low Blood Pressure
- Numbness in hands
- Heart condition / disease
- High Cholesterol
- Cold Feet
- Poor Circulation
- Swelling of Ankles

### Respiratory

- Asthma
- Bronchitis
- Chronic Cough
- Difficulty breathing
- Spitting up phlegm / blood

### Gastro-Intestinal

- Abdominal Distension
- Acid Reflux
- Belching / Burping
- Bloating
- Bloody or Black Stools
- Bowel Impaction
- Candida
- Change in Stool
- Chronic Constipation
- Recent Constipation
- Diarrhea
- Diverticulosis
- Excessive Hunger
- Family History of Colon Cancer
- Fistula or Fissures
- Gallbladder disease
- Gallbladder removed
- Gas
- Heartburn
- Hemorrhoids
- Hernia
- IBS
- Nausea / Vomiting
- Parasites (Intestinal worms)
- Poor Appetite
- Rectal Bleeding / Itching
- Stomach troubles
- Tired after meals

### For Women Only

- PMS symptoms
- Cramps or Backache
- Bloating
- Irritable / Mood Swings
- Weak feeling
- Painful periods
- Heavy Menstrual flow
- Hot flashes
- Hysterectomy
- Irregular cycle
- Lumps in Breasts
- Menopausal Symptoms
- Vaginal Discharge / Sores
- Yeast Infections

### Other Conditions you have ever been diagnosed with:

- Aids
- Alcoholism
- Anemia
- Anorexia / Bulimia
- Appendicitis
- Arteriosclerosis
- Arthritis
- Chicken Pox
- Cancer
- Chronic Fatigue
- Crohn's Disease
- Colitis
- Diabetes
- Edema
- Epilepsy
- Fibromyalgia
- Fibroids
- Goiter / Gout
- Hepatitis
- Heart Attack / Stroke
- Herpes
- Hypo / Hyperthyroidism
- Hypoglycemia
- Lupus
- MS
- Pneumonia
- Stroke
- Measles
- Migraines
- Ulcers
- Small Pox
- Tonsillitis
- Tuberculosis
- Venereal Disease
- Other \_\_\_\_\_



### **Our Financial Policy:**

Thank you for choosing Cleansing Waters as your colon rejuvenation provider. We are committed to your colonic session being successfully completed. Please understand that the payment on your bill is the only way we can continue to provide the best quality service.

The following is a statement of our financial policy, which we would like you to read and sign at the bottom.

**We require full payment at the time of service.** We accept cash, personal checks, MasterCard, and Visa. There is a \$20 minimum charge for all Credit Card transactions and a \$20 charge will be added on all returned checks.

### **Missed/Late Appointments:**

Unless canceled at least 48 hours in advance, it is our policy to charge for missed appointments at the rate of the appointment -- unless we are able to fill the opening from our waiting list. Please help us by keeping your appointment.

Late arrival for a scheduled appointment will be accommodated whenever possible; however, due to scheduling of other clients a full colonic session may not be given to the client that has arrived past a scheduled appointment time.

### **Service Policy:**

Cleansing Waters reserves the right to refuse to offer our services to individuals that we feel *may* be contraindicated to colon hydrotherapy. Clients that we feel are out of our scope of practice may *not* receive services at Cleansing Waters without express written original prescription from a medical practitioner.

### **Packages:**

Cleansing Waters offers colonic packages for discounts on the normal single price. The number of sessions and prices of packages may change.

**All packages are non-refundable and non-transferable.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Curing disease or any other illness is between you and your healthcare/medical professional. CWWC staff does not treat any diseases or illnesses nor do any of our staff make any diagnosis of any illness. CWWC staff are not medical doctors and are not attempting to portray themselves or conduct the activities of medical doctors.



## INFORMED CONSENT – COLON HYDROTHERAPY

*I, the undersigned client, authorize Nancy Spahr or other Certified Colon Hydrotherapists at Cleansing Waters to administer Colon Hydrotherapy sessions. Colon hydrotherapy is a service, not a treatment, and is not intended to be a substitute for careful medical evaluation and treatment by a competent, licensed personal health care professional. Nancy Spahr and her employees are not physicians and therefore are not qualified to diagnose or prescribe. I understand how Colon Hydrotherapy is performed and used, and I acknowledge the potential benefits and risks of Colon Hydrotherapy as described below:*

**COLON HYDROTHERAPY** (colonic) is a gentle method of cleansing the colon of accumulated fecal matter, mucus, harmful toxins and bacteria. The client positions himself/herself on a single-use, disposable sterile rectal nozzle and filtered and sterilized water is run slowly into the colon under control of the client. During one 45-minute session a total of approximately ten (10) gallons of water gently flow into and out of the large intestine. **By signing below, client acknowledges full instructions for use have been given.** Cleansing Waters uses the Jimmy John III® open Colon Hydrotherapy system, which allows the client as much privacy as s/he desires. The Colon Hydrotherapist is *always available* to be present in the room with the client during each session as per the client's expressed wishes.

**Potential risks/possible complications** of hydrotherapy include aggravation of symptoms existing prior to the session, digestive distress (gas), appetite changes, energy changes (tiredness), or minor bleeding. Serious complications are rare, but may occur. Contraindications include severe cardiac disease, severe anemia, GI hemorrhage/perforation, severe hemorrhoids, cirrhosis, carcinoma of the colon, fissures/fistulas, advanced pregnancy, abdominal hernia, recent colon surgery (within 6 months), and renal insufficiency. *If you have any of these conditions or are taking any medications, you must advise Cleansing Waters and consult with your personal health care professional before having any service.* We will review your questionnaire at the first visit before you receive Colon Hydrotherapy to determine whether or not this service is appropriate for you.

- I understand the purpose and potential benefits of colon hydrotherapy, and that it is a wholly elective service.
- I realize no guarantee as to the results that may be obtained has been given to me by Nancy Spahr or any employee of Cleansing Waters.
- An offer has been made to answer my questions about colon hydrotherapy and all questions have been answered to my satisfaction.
- I understand and freely accept the potential risks/possible complications of colon hydrotherapy.
- I freely and voluntarily consent to this service.
- I hereby release Nancy Spahr, her employees, and Cleansing Waters from any and all liability that may occur in connection with the colon hydrotherapy service.
- I understand I am free to withdraw my consent and to discontinue participation in this service **at any time.**

Signature of Client (or of Guardian if under age 18):

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_