**Temple of Wellness Clinic!**

 **1728 E 19 TH ST BROOKLYN, NY 11229**

[**www.templeofwellness.com**](http://www.templeofwellness.com)

**templeofwellness@gmail.com** **/ 347-495-8489**

 **CLIENT REGISTRATION INFORMATION**

Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI \_\_\_\_\_ M / F\_\_\_\_ Date Birth: \_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate if you are having any current problems signs or symptoms:**

**Please put an X beside that is currently a problem. Put P beside a past problem:**

Alcoholism \_\_\_\_ Immunosuppressant \_\_\_\_

Arthritis \_\_\_\_ Infectious Diseases \_\_\_\_

Blood Clots \_\_\_\_ Ulcers \_\_\_\_

Bursitis \_\_\_\_ Migraine Headaches \_\_\_\_

Cancer \_\_\_\_ Muscle Pains \_\_\_\_

Circulatory Problems \_\_\_\_ Pregnant \_\_\_\_

Diabetes \_\_\_\_ Parasites \_\_\_\_

Digestive Problems \_\_\_\_ Recurrent Infections \_\_\_\_

Drug Addiction \_\_\_\_ Respiratory Problems \_\_\_\_

Do you smoke \_\_\_\_ Skin Problems \_\_\_\_

Do you drink alcohol \_\_\_\_ Spinal Injuries \_\_\_\_

Contact lenses wear \_\_\_\_ Sinus problems \_\_\_\_

Epilepsy \_\_\_\_ Tuberculosis \_\_\_\_

Joint Pain \_\_\_\_ Tumors \_\_\_\_

THE FOLLOWING ARE CONTRAINDICTIONS FOR COLON HYDROTHERAPY:

If any of these apply to you, we are not able to treat you with colon hydrotherapy at the present time.

Abdominal Hernia \_\_\_\_ Diverticulosis/ Diverticulitis \_\_\_\_\_ Abdominal Surgery \_\_\_\_ Dialysis Patients \_\_\_\_\_ Abdominal Distention \_\_\_\_ Fissures & fistulas \_\_\_\_\_ Acute Liver Failure \_\_\_\_ Hemorrhaging \_\_\_\_\_ Anemia \_\_\_\_ Hemorrhoidectomy \_\_\_\_\_ Aneurys All Types \_\_\_\_ GI hemorrhage / perforations \_\_\_\_ Carcinoma of the Colon \_\_\_\_ Advanced pregnancy \_\_\_\_\_ Cardiac disease \_\_\_\_ Rectal/Colon Surgery \_\_\_\_\_ Cirrhosis \_\_\_\_ Abdominal Inflammation \_\_\_\_\_

Colitis \_\_\_\_ Renal Insufficiency \_\_\_\_\_

Have you ever had rectal bleeding, if yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE SIGN CONFIRMING DO NOT HAVE ANY OF THE ABOVE CONTRAINDICTIONS

:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_

 GENERAL:

Height\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_ High Blood Pressure? Yes \_\_\_\_\_\_ No\_\_\_\_\_\_

Please list any medications that you are currently taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any supplements that you are currently taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of all surgeries within the last 5 years\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies? (Include foods & medications):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise (type and frequency) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any information about your health which you feel we should know: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How often do you have Bowel Movement?

1 x a day\_\_2 x a day\_\_ 2-3 x a day\_\_ every other day\_\_ 1 x a week\_\_\_ 2 or 2 x a week\_\_\_\_

Do you use a laxative? \_\_\_\_ Herbal laxative\_\_\_\_ Suppositories\_\_\_\_ Enemas \_\_\_ Other\_\_\_\_\_\_\_

Are you currently taking any medication’s, which may weaken the intestinal walls? Yes\_\_\_\_ No \_\_\_\_

BM painful / difficult Yes \_\_\_\_ No \_\_\_\_ Bladder infection Yes \_\_\_\_ No\_\_\_\_

Blood in stool Yes \_\_\_\_ No \_\_\_\_ Burning / Itching Anus Yes \_\_\_\_ No\_\_\_\_

Infections disease Yes \_\_\_\_ No \_\_\_\_ Hemorrhoids Yes \_\_\_\_ No\_\_\_\_

Recent barium enema Yes \_\_\_\_ No\_\_\_\_ Recent colonoscopy Yes \_\_\_\_ No\_\_\_\_

Are you under a MD or ND’s Care? If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have neverbeen diagnosed with any contraindications for colon irrigation. I am responsible for any own self-insertion, if I experience resistance during the insertion, I

will immediately stop my session. If during the session I experience discomfort or pain, I am responsible for immediately stopping my session. This facility does not claim to cure or treat any condition or disease. I acknowledge that the information and service provided is not used to prescribe, recommend, diagnose or treat a health problem or disease. It is not a substitute for medical care. I further acknowledge that alternative methods of available treatment were discussed with me, and that I was given adequate opportunity to ask questions pertaining to this procedure and the alternative methods. I agree to hold harmless any and all personnel of the Living Water Inc. (D.O.B. Temple of Wellness) from any present or future liability arising from any of these

procedures.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client Signature: Date:

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

Therapist Signature: Date:

(For clients 18 or under, the signature & attendance of the parent or guardian for insertion is required.)