



Professional Therapeutic Care Center, LLC.

“For Health, Body and Inner Wellness”

7448 Aloma Ave. suite#2 Winter Park, FL 32792.

407-478-6868

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

Cell phone: _____ E-mail: _____

Place of Employment: _____ Occupation: _____

Birthplace: _____ Date of Birth: ____/____/____ Age: _____ # of Children: ____ Ages: _____

Male ___ Female ___ Blood Type: ____ Height: ____ Weight: ____ Eye color: ____ Hair color: ____

Spouse’s Name: _____ Marital Status: S ,M ,D ,W , other: ____

Who is responsible for this account? _____ Referred by: _____

*In case of an emergency who do we contact? Name: _____

Relationship: _____ Phone # _____ 2nd Phone # _____

MEDICAL HISTORY

Name of Physician: _____ Physician’s Phone # _____

Address: _____ City: _____ State: _____ Zip: _____

Are you pregnant? _____ How far long? _____ Or Are you trying to get pregnant ? _____

Major physical complaints: _____

Are you currently under a physician’s care? _____ If so, explain: _____

Are you on medications? _____ Please list them all: _____

Do you take any vitamins, minerals, or herbal supplements? _____ Please list them:

- | | | | |
|----------|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ | 4. _____ |
| 5. _____ | 6. _____ | 7. _____ | 8. _____ |

List all known allergies: _____

Have you ever:

Had any surgery? Y/N When: _____ Describe: _____

Been in an accident? Y/N When: _____ Describe: _____

Any broken or fracture bones? Y/N When: _____ Describe: _____

Had a Barium Enema? Y/N When: _____ Describe: _____

Had a Sigmoidoscopy? Y/N When: _____ Describe: _____

Had a Colonoscopy? Y/N When: _____ Describe: _____

Had a Colon, Rectal or Gastrointestinal procedure? Y/N When: _____ Describe: _____

Daily Routine

How do you rate your stress in your life style? Circle best (Light, Moderate , Heavy)

Can you relax easily? Y / N Are you easily excited or upset? Y / N

Do you exercise in a week? Y / N How often _____ What Kind? _____

What do you do for recreation? _____

What do you do for relaxation? _____

HEALTH CONDITIONS

Please take your time review and **circle** all that apply currently (c) or in the past (p):

- | | | |
|------------------------|--------------------------------|--------------------------|
| Abdominal pain | Chronic cough | Frequent headaches |
| Anemia | Colitis | Gallbladder disease |
| Arteriosclerosis | Constipation-chronic | Gas |
| Arthritis | Constipation-recent | Hands-cold or numbness |
| Asthma | Crohn’s disease | Heartburn |
| Back pain | Depression | Heart condition |
| Bloating | Diabetes | Heart disease |
| Blood clots | Diarrhea | Hemorrhoids |
| Bloody or black stools | Diverticulitis | Hepatitis |
| Blood pressure-High | Dizziness | Hernia |
| Blood pressure-Low | Double/blurred vision | Herniated disc |
| Body odor | Ears ringing | High cholesterol |
| Bowel impaction | Edema | History of seizures |
| Breast pain | Emphysema | Irritable bowel syndrome |
| Bronchitis | Enlarged thyroid | Parasites |
| Bruise easily | Fainting spells | Ulcerative colitis |
| Bursitis | Family history of colon cancer | Ulcers |
| Cancer | Fatigue | Underweight |
| Candida | Feet-cold | Vaginal discharge |
| Change in stool | Fistula or fissures | Varicose veins |
| Chest pain | Foot numbness | |

Colon Hydrotherapy

Colon Hydrotherapy is a safe and effective method of cleansing your large intestine (colon). We do not diagnose diseases and/or prescribe medication. It is your responsibility to provide health information and for you to inform us of any change. Any and all information shared with you in this clinic is for educational purposes only.

Colon History

Have you ever had colon Hydrotherapy? Y / N If yes, when was your last colonics? ____/____/____

How many? ____ How often? _____ Where? _____

What do you hope to accomplish with your colonic session today? _____

How often do you have bowel movements? _____

How would you best describe your bowel movements? _____

Straining? _____ With ease? _____ Discomfort? _____

Explain discomfort? _____

Describe size and shape of your waste: (pellets, pencil, banana like?): _____

Have you ever had rectal bleeding? ____ If so, when? ____ Did you see a doctor? _____

Do you have hemorrhoids or other rectal problems? _____

Do you use laxatives? Y / N How often? _____ Which? _____

Dietary Habits:

Describe your intake of the following (please indicate Heavy(H) , Moderate(M), Light (L), None(N).

- | | | |
|-------------------------------|-----------------------|----------------------------|
| Alcohol- ____ | Oats- ____ | Soy- ____ |
| Beans- ____ | Pork- ____ | Sugar- ____ |
| Coffee- ____ | Poultry- ____ | Sweets- ____ |
| Fruits/veggies (fresh)- ____ | Processed foods- ____ | Tea- ____ |
| Fruits/veggies (frozen)- ____ | Raw foods- ____ | Tobacco- ____ |
| Fruits/veggies (canned)- ____ | Salads- ____ | White flour breads- ____ |
| Grains- ____ | Salt- ____ | Whole wheat products- ____ |
| Meat (red)- ____ | Seafood- ____ | |
| Milk/cheese/butter- ____ | Soda- ____ | |

Circle which one best describe your diet (Standard american, Vegan, Vegetarian, Low carb, Raw?)

Where do you eat most of your meals? Home ___% Restaurant _____ %

How many glasses of water do you drink a day? _____

Do you fast or diet? Y / N if yes, how often? _____

Colon Hydrotherapy Release

I understand and agree that Colon Hydrotherapy services provided by this state certified Colon Hydrotherapist is provided pursuant to and in accordance with the laws of the state of florida governing Colon Hydrotherapy and that full and complete medical history disclosure is essential in providing such therapy. I agree to hold harmless, release and indemnify this state certified colon Hydrotherapist against any and liability arising from the application of Colon Hydrotherapy. By signing this release I hereby declare that I have provided to this Colon Hydrotherapist with all relevant information necessary for the proper application of Colon Hydrotherapy. I give my permission for this Colon Hydrotherapist to provide such therapy.

Signature: _____

Date: ____/____/_____

Services rendered are payable at time of service unless special arrangements have been made in advance of your session. For your convenience we accept visa, master card, debit check cards or cash.

Initial _____

Cancellation Policy

At Professional Therapeutic Care Center, LLC. We value you. Therefore, we are sure that you understand your time is as valuable as ours is.

To provide you with the best service, it is important for you to be on time for your appointment.

- if you are running late, please call our center to let us know... and understand that we may need to reschedule your appointment.
- if you are unable to make your appointment, we ask a 24 hour cancellation notice. If you are unable to give us a 24 hour cancellation notice, we reserve the right to charge you a \$30 cancellation fee.

Signature: _____

Date: ____/____/_____