CLEANSING *Waters*
Total Body Cleansing

Please complete the Health Questionnaire prior to your scheduled appointment and bring with you!

Confidential Health Questionnaire

Today's Date:_____ **Referred By:**_____

Name:_____ **M___ F___ Birthdate ___/___/___ Age:**_____

Mailing Address:_____

City:_____ **State:**_____ **Zip:** _____**Occupation:**_____

Cell Phone (____)_____**Work (___)**_____ **Home (___)**_____

Height:_____ **Weight:**_____ **Marital Status: S___M___D___W___ No. of children**_____

E-mail Address: _____

The nutritional and health information provided by Nancy Spahr or Cleansing Waters, LLC staff during any consultation, meeting, in newsletters, or handouts is based on personal experience, research and experiences of their clients. This information is to be used for educational purposes. It is to help you make informed decisions regarding the state of your health and how your lifestyle choices affect your health. Because there is always some risk involved when changing diet and lifestyle, please do not apply this information unless you are willing to assume the risk. If you choose to use diet and lifestyle changes as a form of treatment for illness or disease without the approval of a medical physician, you are prescribing for yourself, which is your constitutional right.

_____

>>>>>I agree to accept the terms of this disclaimer and acknowledge that any information I receive from Nancy Spahr is to be used for educational purposes in order to assist me in making the best decisions concerning my own health. I acknowledge that they are not Medical Doctors and that they will not prescribe or diagnose any disease or condition. I agree to accept all responsibility for any decisions I choose to make concerning the self-prescription of any treatments that may be discussed and will not hold them liable for my decisions or the results of those decisions. To the best of my knowledge, all of the answers in this questionnaire are true and correct. **If any changes in my health or medications occur, I will inform Nancy Spahr or Cleansing Waters, LLC staff at my next appointment.**

Cancellation Policy: *I understand that Cleansing Waters has a 24 hour cancellation policy that must be strictly enforced. I may cancel my appointments by phone or by using the on-line scheduler. Email cancellations cannot be accepted. I agree that a charge of $70 or a session will be removed from my series/package if I fail to make the 24 hour deadline. A returned check fee is $30.*

Client Name: _____Client Signature: _____Date:_____

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General Health Information

Check the services you expect to receive today.

____ Colonics ____ (BEA) Avatar Assessment ____ SOQI Spa (FIR HotHouse & Chi Machine)

___ Electro Reflex Energizer (ERE) ____ E-Power ____ Maya/Thai Massage ____ MicroExfoliation

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

_____

_____

List all medications that you are currently using (please include why you are taking them if possible). include non-prescription medications such as aspirin, laxatives, anti-acids

_____

_____

List supplements (vitamins, minerals, herbs, homeopathic) you are taking on a regular basis:

_____

_____

List the date and type of any surgeries you have had? _____

_____

If you are currently under medical treatment elsewhere, please list the health issue and the practitioner's name: _____

_____

LIFESTYLE

Yes No 1. Do you smoke?
Yes No 2. Do you drink coffee? How Much _____?
Yes No 3. Do you drink soda? How Much _____?
Yes No 4. Do you drink water daily? How Much_____? What Type?_____
Yes No 5. Do you use a microwave? _____
Yes No 6. Trouble Sleeping? How many hours per night? _____
Yes No 7. Do you have electronics turned on in your bedroom at night? (cell,tv,computer)
Yes No 8. Do you exercise? ____daily ____ 2-4 times/week _____ once a week

***HEALTH CHALLENGES** - Rate from 1-No Problem to 5-Serious Problem*

1 2 3 4 5 Digestive
1 2 3 4 5 Mental Clarity(Mental Fog, forgetful)
1 2 3 4 5 Sleep Issues
1 2 3 4 5 Back/Joint/Muscle Pain
1 2 3 4 5 Anxiety/Depression
1 2 3 4 5 Headaches (tension, migraines)
1 2 3 4 5 Energy/Fatigue
1 2 3 4 5 Skin Issues (rash, itching ,dry, sores)
1 2 3 4 5 Circulation/CardioVascular
1 2 3 4 5 Blood Sugar (diabetes, hypoglycemia)
1 2 3 4 5 Immune System (get sick easily)
1 2 3 4 5 Stress Level (work, home, family)
1 2 3 4 5 Urination Problems
1 2 3 4 5 Level of Inner Joy/Peace
1 2 3 4 5 Hormonal Problems (PMS, Menapause)
1 2 3 4 5 Hair Loss or Nail Disorders
1 2 3 4 5 Weight Issues (over or under)
1 2 3 4 5 Allergies (food or environmental)
1 2 3 4 5 Lung Congestion/ Coughs
1 2 3 4 5 Addictions
1 2 3 4 5 Lymph (edema, swollen glands)
1 2 3 4 5 Teeth/Gum Problems

OXYGEN, ENERGY & LIGHT THERAPY

Experience a unique full body massage, total relaxation, stress relief and an overall feeling of peace and wellness.

Do you have problems with: *(Please check all that apply)*

_____ Lack of exercise	_____ General pain	_____ Poor digestion
_____ Arthritis, Back pain, bone spurs	_____ Insomnia	_____ Fibromyalgia
_____ Asthma & tracheal inflammation	_____ Tired & sore muscles	_____ Menstrual pains, anemia
_____ Poor circulation	_____ Overweight	_____ Fluid retention
_____ Diabetes	_____ Stress	_____ Constipation

Many have reported improvement with the above problems as well as many other problems.

Health Questions

I understand that I should consult with my physician before use if I am recovering from surgery, have a serious infection or bleeding injury, have heart disease, bone fractures, a pacemaker, pregnancy or epilepsy.

Do you wear a pacemaker or use a heartbeat regulating medicine? Yes / No

Have you had an organ transplant? Yes / No

Do you have any metal plates, pins, rods, or screws? Yes / No

Do you suffer from seizures or been diagnosed with Epilepsy? Yes / No

Are you pregnant or lactating? Yes / No

Do you have a fracture or any open wounds? Yes / No

Have you been diagnosed with a bleeding disorder or take blood thinners? Yes / No

Do you have advanced stages of diabetes? Yes / No

Explain your present health: _____

Have you eaten within 30 minutes _____ Please drink a glass of water before and after the therapy session!

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

IMPORTANT NOTE: I understand that with any session there are always unforeseen risks. I take full responsibility of my actions and do not hold AQUADVIDA USA LLC or CLEANSING WATERS LLC accountable for my decision to have a session. Initials: _____ I waive the right to any claims that I may have now or in the future in regards to the foot spa session I am about to experience. Initials: _____

By signing this sheet I authorize Nancy Spahr or other employees of Cleansing Waters to administer a session using the AquaVida® foot spa, Chi Machine, Hothouse, Advanced Electro Reflex Energizer or E-power. I understand these services are not intended to be substitutes for careful medical evaluation and treatment by a competent, licensed personal health care professional. The staff of Cleansing Waters, LLC are not physicians and therefore are not qualified to diagnose or prescribe. I agree not to hold anyone liable for any side effects that may occur during or after the use of the AquaVida® foot spa, Chi Machine, Hothouse, Advanced Electro Reflex Energizer or E-power.

Colon Hydrotherapy and Digestive Information

Indications for Colon Cleansing/Hydration - *Colon Cleansing/Hydration has been shown to be beneficial for any the following:*

Abdominal Distention
Hemorrhoids (mild-moderate)
Constipation
Intestinal Toxemia
Colitis
Fecal Impaction
Diarrhea
Parasitic Infections
Imbalance of Intestinal Flora
Prevention
Diagnostic Preparation of Large Intestines:
- Pre-colonoscopy
- Sigmoidoscopy
- Barium Enema

Bowel Movement Frequency: ___ Daily ___ skip days ___ 1-2 times/week ___ Must strain
Bowel Movement Type: ___ Sausage –like ___ loose ___ pencil shaped ___hard small balls
___Painful _____Last Bowel movement

Are you in pain at this time? Y N Bloating/Gas? ___ Hemorrhoids ? ___ Other?_____

Check the Digestion Issues you have experienced in the last 60 days.

- ☐ Bloating
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Colitis
- ☐ IBS
- ☐ IBD
- ☐ Diverticulosis
- ☐ Diarrhea
- ☐ Tired after meals
- ☐ Abdominal pain
- ☐ Bloody/Black Stools
- ☐ Heartburn
- ☐ Acid Reflux
- ☐ Hernia
- ☐ Indigestion
- ☐ Stomach Ulcers
- ☐ Intestinal Ulcers
- ☐ Crohns Disease
- ☐ Rectal Itching
- ☐ Food allergies /sensitivities
- ☐ Parasitic infections
- ☐ Candida/Yeast
- ☐ Belching
- ☐ Gallbladder troubles

Contraindications ---The following is a list of contraindications to Colon Cleansing/Hydration. If you have ever been diagnosed with ANY of these conditions a colonic should not be administered without a doctor's prescription/release. 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, LLC without express written original prescription from a medical practitioner. *Check any that pertain to you.*

- ☐ Abdominal Hernia
- ☐ Abdominal Surgery (Recent)
- ☐ Acute Liver Failure
- ☐ Anemia (severe)
- ☐ Aneurysm
- ☐ Carcinoma of the Colon
- ☐ Severe Hemorrhoids
- ☐ Severe Cardiac Disease (uncontrolled hypertension)
- ☐ Cirrhosis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Dialysis Patient
- ☐ Diverticul***itis***
- ☐ Fistulas and Fissures
- ☐ GI Hemorrhaging
- ☐ GI Perforation
- ☐ Lupus
- ☐ Pregnancy(1st Trimester & advanced)
- ☐ Colon or Rectal Surgery
- ☐ Renal Insufficiencies

Client Name: _____Client Signature: _____Date:_____