ALIST WELLNESS CENTER LLC

25 EAST WILLOW ST.
MILLBURN, NEW JERSEY 07041

CLIENT REGISTRATION INFORMATION

In order to serve you properly, we will need the following information. **(Please print)**

Last name: _____First name: _____Initual:_____

Address: _____City: _____ State: _____ Zip_____

Date of Birth: _____Age: _____ M /F_____ Marital Status_____

Home phone: _____Cell phone: _____Email:_____

Employer_____ Your occupation: _____Work phone: _____

EMERGENCY CONTACT INFORMATION:

Name of person: _____Relationship _____

Address: _____City:_____Zip:_____

Home phone: _____ Work: _____ Cell: _____

CLIENT REFERRAL INFORMATION:

Referred by: _____ If referred by a friend, may we thank her or him? YES___NO____

Phone Book _____Referral _____Website_____ TV ____NJ Naturally____Other_____

Doctor's Name: _____phone:_____

Please follow the instructions of the Therapist. You must be draped/covered at all times.

Signature: _____ Date: _____

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25 EAST WILLOW ST
MILLBURN, NJ 07041
TEL: 973-912-4448 FAX: 973-912-4459

CONSENT FOR OFFICE PROCEDURE

I, _____, herby **authorize / consent** to **allow Certified Practitioners** of Alist Wellness Center LLC, to perform alternative therapies. The therapies offered to me are Colon Hydrotherapy. Colon Hydrotherapy is not intended to replace the relationship with your primary health care providers and my consultation is not intended as a Colon Hydrotherapist is not medical advice. They are intended as a sharing of knowledge and information from my education, research, training, and experience. As a Colon Hydrotherapist, I encourage you to be open to new information on the effectiveness of Colon Hydrotherapy and the fundamental role of diet, exercise, supplementation, stress management and emotional and mental work. I encourage you to make your own health decisions based upon your research and in partnership with your primary health care providers, ND, MD or otherwise.

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 Alist Wellness Center LLC from any present or future liability arising from any of these procedures.

_____ _____

Client Signature: **Date:**

_____ _____

Therapist Signature: **Date:**

Cancellation Policy:

Cancellations or changes to scheduled appointments must be made 24 hours in advances of the scheduled appointment. Otherwise, you will be billed for the cost of service as a cancellation charge. Any check returned for insufficient funds will be subject to a $35.00 processing fee.

If you calling after business hours, please leave a message on our voicemail indicating your appointment cancellation. The same charge applies for missing an appointment. Thank you.

Signature: _____ Date: _____

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HEALTH HISTORY

Name: _____
(Last Name) (First Name)
Reason for Visit: _____Date:_____

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	____

GENERAL: Height____ Weight____ History of 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 in which you feel we should know:

_____

What do you hope to achieve for this appointment? _____

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ADDITIONAL HEALTH HISTORY
FOR COLON HYDROTHERAPY

A contraindication is any indication or symptom that makes it inadvisable to use a particular therapy.

How often do you have BM? 1 x a day_____ 2 x a day_____ 2-3 x a day_____ 1 x a week_____

Do you use a laxative? _____Herbal laxative_____ Stool softener_____ Suppositories___ Enemas_____

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	____
Aneurysm All Types	____	GI hemorrhage / perforations	____
Carcinoma of the Colon	____	Lupus	____
Cardiac disease	____	Advanced pregnancy	____
Cirrhosis	____	Rectal/Colon Surgery	____
Colitis	____	Renal Insufficiency	____

Are you currently taking any medication's, which may weaken the intestinal walls? Yes____ No ____

PLEASE SIGN CONFIRMING DO NOT HAVE ANY OF THE ABOVE CONTRAINDICTIONS:

SIGNATURE: _____DATE:_____

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____

Have you ever had rectal bleeding, if yes, when? _____

Are you under a MD or ND's Care? If yes, please explain: _____
_____

I have never been diagnosed with any contraindications for colon irrigation. I am aware that colon irrigation and enema device user facilities are not physicians and therefore do not insert, diagnose or prescribe. I am aware adverse events such as perforation, injury and illness have alleged and claimed with the use of colon irrigation and enema devices. 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.

Client Signature: x_____ Date: ____/____/____
(For clients 18 or under, the signature & attendance of the parent or guardian for insertion is required.)