LIFE FAMILY PRACTICE CENTER
1501 US Hwy 441 North Bldg 1700, The Villages, FL 32159
Tel# (352) 750-4333

Personal Information

Name: _____ Date: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____

Occupation: _____ Place of Employment: _____

Height: _____ Weight: _____ Blood Type: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Number of children (names & ages): _____

Do you have any pets? ___ If so, what kind and what are their names: _____
_____

Who is responsible for this account? _____

Referred by: _____

Who would we contact for you in case of an emergency?

Name: _____ Relationship: _____

Home Phone: _____ Work: _____ Cell: _____

Medical History

Are you under a doctor's care? _____

Doctor's name: _____ Doctor's Phone number: _____

Major physical complaints: _____
_____

Are you pregnant? _____ If yes, please see the receptionist because we cannot administer some services for you at this time.

Patient's Initials: _____

Have you had any surgeries? _____ If yes, when, and please describe: _____
_____

Have you had any accidents? _____ If yes, when and please describe: _____
_____

Have you had any broken bones? _____ If yes, when and please describe: _____
_____

Please list all known allergies: _____
_____

Are you allergic to latex? _____

Please list all medications and supplements you are taking: _____
_____

Are you currently seeing a psychotherapist or attending regular support group meetings?___

If yes, please explain: _____

Food Consumption / Food Diary

For the food listed below, please indicate the amount of consumption weekly.
(**N**one **L**ight **M**oderate **H**eavy)

Sweeteners	Sugar	Honey	Syrup	Tobacco
Coffee	Tea	Soda	Alcohol	Salt
Beans	Salads	Sprouts	Potatoes	Spices
Canned Fruit	Protein bars	Cereals	Cookies	Cakes
Chocolate	Ice Cream	Eggs	Butter	Milk/Dairy
Cheese	Yogurt	Beef	Pork	Poultry
Fish	Shellfish	Bread	Bagels	Oat
Wheat	Barley	Rye	Rice	Pasta
Soy	Corn	Fast Foods		
Fresh Vegetables	Frozen Vegetables	Canned Vegetables	Fresh Fruit	Frozen Fruit

In this section, list the foods you ate yesterday or eat on a typical day. Include everything you ate and drank, listing the amounts. Be specific about the types of food (i.e. white or brown bread, fried potatoes, etc.).

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient's Initials: _____

Daily Routine

How do you rate (**L**ight, **M**oderate, **H**eavy) the stress in your daily life at:

Home_____ Work_____

How often do you exercise in a week? _____ What type of exercise? _____

What do you do for relaxation? _____

What do you do for recreation? _____

Dietary Habits

Where do you eat the majority of your meals? Home: ____ % Restaurant: ____ %

How much water do you drink a day?

8 oz (cup) ___ 16 oz (pint) ___ 32 oz (quart) ___ 64 oz (1/2 gal) ___ 128 oz (gal) ___

What do you hope to accomplish from your appointment today?

_____
_____
_____

Patient's Initials: _____

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Health Conditions

Please place a **check mark** if you have had any of the following **in the last 30 days.** Place an **X** if you have had any of the following in the past.

___ recent constipation	___ family history of colon cancer	___ heart disease
___ chronic constipation	___ underweight	___ cancer
___ diarrhea	___ overweight	___ Candida
___ parasites	___ diabetes	___ body odors
___ colitis	___ high cholesterol	___ heartburn
___ ulcerative colitis	___ high blood pressure	___ obesity
___ bowel impactions	___ low blood pressure	___dizziness
___ hemorrhoids	___ frequent headaches	___ fainting spells
___ diverticulitis	___ migraine headaches	___ nervousness
___ bloody or black stools	___ history of seizures	___ bloating
___ fistula or fissures	___ insomnia	___ hepatitis
___ ulcers	___ irritability	___ anemia
___ hernia	___ shortness of breath	___ arthritis
___ Chron's disease	___ chronic cough	___ emphysema
___ abdominal pain	___ painful menstruation	___ bronchitis
___ vomiting	___ vaginal discharge	___ asthma
___ change in stool	___ breast pain	___ fatigue
___ gas, belching	___ poor circulation	___ depression
___ low blood sugar	___ painful urination	___ liver trouble
___ kidney failure	___ blurred vision	___ bruise easily
___ gallbladder disease	___ kidney stones or infection	___ dry skin
___ prostate trouble	___ enlarged thyroid	___ skin rash

Patient's Initials: _____

Contraindications for Colon Hydrotherapy

- Severe Cardiac disease: e.g. uncontrolled hypertension
- Congestive heart failure of organic valve disease
- Aneurysm
- Severe Anemia
- GI hemorrhage / perforation
- Sever hemorrhoids
- Cirrhosis
- Carcinoma of the colon or rectum
- Fissures / fistulas
- Advanced pregnancy
- Abdominal hernia
- Recent colon or rectum surgery
- Renal insufficiency
- Advanced Crohn's
- Advanced ileitis

If you have any of the conditions listed above, Colon Hydrotherapy can NOT be done!

Please initial that you have reviewed the contraindication list

_____ _____

NAME **DATE**

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Colon Hydrotherapy is an effective method of cleansing your large intestine (colon). Your therapist does not diagnose disease or prescribe medication. It is your responsibility to provide pertinent health information and to inform the therapist of any changes.

RELEASE: I understand and agree that Colon Hydrotherapy services provided by this State Certified Colon Hydrotherapist are 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 Hydrotherapist with all relevant information necessary for the proper application of Colon Hydrotherapy and I expressly give my permission for this State Colon Hydrotherapist to provide such therapy.

Signature: _____ **Date:** _____