13740 Research Blvd C3
Austin, TX 78750
Karen Million, RMT, CCH, MTI
512-825-0226

Name: _____Age _____Gender _____Date_____
Address: _____City_____State____Zip _____
email: _____Phone_____
Work phone: _____ Referred by: _____Occupation:_____

Please answer the questionnaire so that I may best serve your needs. Circle all the symptoms that you now have, any past symptoms put a "P" next to it.

YOUR HEALTH HISTORY IS CONFIDENTIAL! (Please circle all that apply)

<u>General Symptoms.</u>

Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Insomnia
Fatigue
Nervousness
Depression
Weight Loss
Allergies
Numbness in _____

Respiratory
Cough
Spitting up phlegm
Chest Pain
Difficult Breathing

Failing Vision
Near Sighted
Eye Pain
Deafness
Earache
Ear Noise
Nose Bleeds
Sore Throat
Swollen Lymph Glands

<u>Skin</u>

Skin Eruptions
Itching
Bruises Easily
Dryness
Acne
Varicose Veins
Hive or Allergies

High Blood Pressure
Low Blood Pressure
Pain over Heart
Heart Attack
Swollen Ankles
Poor Circulation

<u>Genito-Urinary</u>

Frequent Urination
Painful Urination
Blood in Urine
Pus in Urine
Kidney Trouble
Incontinence
Prostate Trouble
No Urination

<u>Cardio-Vascular</u>
Rapid Heartbeat
Slow Heartbeat

Gastro-Intestinal

Lack of Appetite
Constant Hunger
Difficult Digestion
Belching or Gas
Bloating
Nausea
Vomiting
Vomiting Blood
Pain over lower abdomen
Pain over stomach
Constipation
Diarrhea
Hemorrhoids
Rectal Bleeding
Bloody Stool
Parasites
Liver Problems
Gall Stones
Hepatitis
Jaundice

Women Only

Irregular Cycle
Tremors
Hot Flashes
Excessive Flow
Painful periods
Are you pregnant? Yes No

Muscle, Bone Joint

Swollen or stiff joints
Pain in _____
Lower backache

Please list all Prescription Drugs: _____

_____

_____

Medical Indications for the Use of Colon Hydrotherapy: Check all that apply
_____For Endoscopic or x-ray radiological examination

_____Constipation or Fecal Impaction

_____Other: Describe_____

BP _____ Weight_____ Reviewing Physician _____

VERY IMPORTANT! Have you had within the past 6 months been diagnosed with any of the following: (Please circle the appropriate answer)

Cardiac disease or Congestive Heart Failure	Yes	No
Intestinal perforation	Yes	No
Carcinoma of the Rectum	Yes	No
Aneurysm or Abdominal Surgery	Yes	No
Severe Hemorrhoids	Yes	No
Fissures or Fistula	Yes	No
Abdominal Hernia	Yes	No
Cirrhosis of the Liver	Yes	No
First and last trimester of pregnancy	Yes	No
Renal insufficiency – difficulty urinating	Yes	No
Recent colon or rectal surgery	Yes	No

I have read the above contraindications for having a colonic and agree that I have disclosed all pertinent medical information regarding my physical condition and <u>do not</u> have any of the above conditions. In addition, I have evaluated all information given to me concerning the colonic procedure and I release Lake Travis Wellness Center from any problems resulting from procedures in which I voluntarily participate.

_____

Signed (Client) **Date**

_____

Print Name

_____

Street Address

_____ _____ _____

City **State** **Zip**

By history, Client is cleared for colon hydrotherapy as needed for a one year period.

_____ Date _____

Prescribing Doctor's Signature

Lake Travis Wellness Center – 512-825-0226

INFORMED CONSENT

Lake Travis Wellness Center and **Lake Travis Pain Clinic**, (Karen Million, Colon Hydrotherapist) does not do the following things:

1. I do not diagnose
2. I make no attempt to cure any condition
3. I make no claim or imply any claim that suggestions are given to cure any conditions.
4. I do not claim that any supplemental material that I speak about will cure any condition or that its purpose is to treat any condition.
5. I do not prescribe or treat disease, however I do attempt to educate you on food and conscious diet choices, exercise and lifestyle choices if they are not contradictory to the recommendations of your primary health care provider or your physician.

I, the undersigned client of **Lake Travis Wellness Center** and **Lake Travis Pain Clinic**, understand the above statements and understand that diet and nutrition is considered to be an inexact science and that the results obtained are not always consistent or predictable. Whether or not I participate in the procedures offered by **Lake Travis Wellness Center** and **Lake Travis Pain Clinic** is my decision based on my constitutional right of the 9th Amendment. I understand that Karen Million, the colon hydrotherapist, is not a medical doctor and is not attempting to portray or conduct the activities of a medical doctor, and I waive any liability on behalf of the colon hydrotherapist.

NAME: _____ DATE: _____

ADDRESS: _____ ZIP: _____

SIGNATURE: _____ PHONE: _____