

**Personal History Form**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Work and/or Interests \_\_\_\_\_

**Please check all of the following symptoms, which you now have or have had previously. Be as thorough as possible! Your health history is strictly confidential.**

**General Symptoms**

Headache  
 Fever  
 Chills  
 Sweats  
 Fainting  
 Allergy  
 Dizziness  
 Convulsions  
 Loss of sleep  
 Fatigue  
 Nervousness/depression  
 Loss of weight  
 Overweight  
 Numbness in \_\_\_\_\_

**Eyes, Ears, Nose, Throat**

Failing vision  
 Near sightedness  
 Far sightedness  
 Crossed eyes  
 Eye pain  
 Deafness  
 Earache  
 Ear noises  
 Ear discharge  
 Nose bleeds  
 Nasal obstruction  
 Nasal drainage  
 Sore throat  
 Swollen tonsils  
 Enlarged lymph glands  
 Enlarged thyroid  
 Hoarseness  
 Colds  
 Sinus infection

**Skin**

Skin eruptions  
 Itching  
 Bruises easily  
 Dryness  
 Boils  
 Varicose veins  
 Sensitive skin  
 Hives or allergies

**Respiratory**

Chronic cough  
 Spitting up phlegm  
 Spitting up blood  
 Chest pain  
 Difficult breathing

**Cardio-vascular**

Rapid heart beat  
 Slow beating heart  
 High blood pressure  
 Low blood pressure  
 Pain over heart  
 Heart attack  
 Swelling of ankles  
 Poor circulation

**Muscle, Bone & Joint**

Stiff neck  
 Backache  
 Swollen joints  
 Tremors  
 Painful tailbone  
 Foot or ankle trouble  
 Pain in: shoulders, hips, legs,  
 knees, feet, other? \_\_\_\_\_  
 Hernia, spinal curvature  
 Faulty posture

**Genito-urinary**

Frequent urination  
 Painful urination  
 Blood in urine  
 Pus in urine  
 Kidney trouble  
 Inability to control urine  
 Prostate trouble

**Gastro-intestinal**

Poor appetite  
 Excessive hunger  
 Difficult digestion  
 Belching or gas  
 Distention of abdomen  
 Nausea  
 Vomiting  
 Vomiting of blood  
 Pain over stomach  
 Pain over lower abdomen  
 Constipation  
 Diarrhea  
 Colon trouble  
 Bloody stools  
 Intestinal parasites  
 Liver trouble  
 Gall bladder trouble  
 Jaundice

**For Women Only**

Painful menstrual periods  
 Excessive menstrual flow  
 Hot flashes  
 Irregular cycle  
 Cramps or backache  
 Miscarriage  
 Vaginal discharge  
 Lumps in breast

**Check any of the following conditions you now have:**

Dental cavities	Diabetes	Goiter	Multiple sclerosis	Small pox
Gum trouble	Diphtheria	Gout	Nervous breakdown	Tuberculosis
Appendicitis	Eczema	Heart problems	Pneumonia	Ulcers
Arteriosclerosis	Emphysema	Malaria	Polio	Venereal infection
Arthritis	Epilepsy	Measles	Rheumatic fever	Whooping cough
Cancer	Fever blisters	Mental disorders	Mumps	Scarlet fever
Chicken pox	Colitis	Flu	Stroke	Other _____

**Have you ever:**

**Please describe the what and when of any situation below:**

Had any unusual accidents or falls?

\_\_\_\_\_

Had any bone fractures?

\_\_\_\_\_

Been knocked unconscious?

\_\_\_\_\_

Had any surgical operations?

\_\_\_\_\_

**Habits:**

Sleep – Hours daily? \_\_\_\_\_ Is it enough? \_\_\_\_\_

Exercise – Daily? \_\_\_\_\_ Is it enough? \_\_\_\_\_

Fresh Air – Daily? \_\_\_\_\_ Is it enough? \_\_\_\_\_

Water – Daily? \_\_\_\_\_ Is it enough? \_\_\_\_\_

Food – Too much or little? \_\_\_\_\_ Is it enough? \_\_\_\_\_

Positive Attitude – Consistent? \_\_\_\_\_

Emotions – Do you feel they are in balance? \_\_\_\_\_

Do you use any of the following on a daily basis?

Alcohol      Coffee      Tea      Tobacco

Supplements:

Vitamins:

Minerals:

Herbs:

**Most recent medical service/hospitalization?** – For what, where and when \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Your #1 health goal or concern at this time?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Client

**Medical Indications for Use of Colon Hydrotherapy**

Check all that apply:

\_\_\_\_\_ For endoscopic or x-ray/radiological examination

\_\_\_\_\_ Constipation or fecal impaction

\_\_\_\_\_ Other: Describe \_\_\_\_\_

**Contraindications for Use of Colon Hydrotherapy**

Have you had within the last 6 months:

	YES	NO
• congestive heart failure	_____	_____
• intestinal perforation	_____	_____
• carcinoma of the rectum	_____	_____
• fissures or fistula	_____	_____
• severe hemorrhoids	_____	_____
• abdominal hernia	_____	_____
• renal insufficiency	_____	_____
• recent colon or rectal surgery	_____	_____
• abdominal surgery	_____	_____
• first and last trimester of pregnancy	_____	_____
• cirrhosis	_____	_____

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Client Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Client is cleared for colon hydrotherapy as needed for a 6-month period.

\_\_\_\_\_ Date \_\_\_\_\_

Prescribing Doctor's Signature

Dr. Gary Albertson

TEX Lic #D7899

## Informed Consent

Regenesis Integrative Health Centers informs you of the following things:

1. We do not diagnose.
2. We make no attempt to cure any condition.
3. We make no claim or imply any claim that suggestions are given to cure any condition.
4. We do not claim that any supplemental material that we speak about will cure any condition or that its purpose is to treat any condition.
5. We do not prescribe or treat disease, however we 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 Regenesis Integrative Health Centers, understand the above statements and understand that diet, nutrition, and lifestyle consultations are considered to be inexact sciences and that the results obtained are not always consistent or predictable.

Whether or not I participate in the procedures offered by Regenesis Integrative Health Centers is my decision based on my God-given inalienable rights and my constitutionally guaranteed rights secured by the U.S. Bill of Rights. It is my Creator-endowed Inalienable Right to ask for assistance of my own choosing and I accept full responsibility for any outcome. I understand that there is no guarantee of any result and the opposite of the desired result may appear. Whether or not I ask for assistance is my decision. All decisions relative to my health must be made by me.

I understand that all the practitioners here are not medical doctors and are not attempting to portray or conduct the activities of a medical doctor, and I waive any liability on behalf of the practitioner.

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Signature \_\_\_\_\_ Phone \_\_\_\_\_