

Natural Health Associates, LLC

921 East Central Avenue

Miamisburg, OH 45342

Confidential Request for Procedure

(Please answer all questions and checkmark (✓) those that apply.)

DATE _____

NAME _____ Home Tel. _____ Work Tel. _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

OCCUPATION _____ HOW LONG? _____

HEIGHT _____ WEIGHT _____ BIRTHDATE _____ AGE _____ Male/Female _____

Why have you chosen to have colon irrigation session(s)?:

- Reason _____
- In pain? Yes ___ No ___ Where? _____
- ___ Bladder Infection ___ Bloating ___ Blood in Stool ___ BM Painful/Difficult
- ___ Burning/Itching Anus ___ Constipation ___ Diarrhea ___ Infectious Disease
- ___ Internal Hemorrhoids ___ External Hemorrhoids ___ Rectal Bleeding
- ___ Recent Barium Enema ___ Recent Colonoscopy ___ Strain at Stool ___ Use Laxatives
- ___ Vomiting _____ Date of Last Menstruation ___ Other _____
- ___ Other(s) _____
- Under a medical/chiropractor provider's care? Yes ___ No ___
- Medical/chiropractor provider's name _____
- Colon irrigation service requested by written order Yes ___ No ___
- Physician/chiropractor's written order expiration date: _____

***** Contraindications *****

(√) and date if you ever had or been diagnosed with any of the following:

	<u>Date</u>		<u>Date</u>
<input type="checkbox"/> Abdominal Hernia	_____	<input type="checkbox"/> Diverticulosis	_____
<input type="checkbox"/> Diverticulitis	_____	<input type="checkbox"/> Fistula	_____
<input type="checkbox"/> Abdominal Surgery	_____	<input type="checkbox"/> Fissure	_____
<input type="checkbox"/> Abnormal Distension	_____	<input type="checkbox"/> Hemorrhaging	_____
<input type="checkbox"/> Acute Liver Failure	_____	<input type="checkbox"/> Hemorrhoidectomy	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Intestinal Perforations	_____
<input type="checkbox"/> Aneurysm – All Types	_____	<input type="checkbox"/> Lupus	_____
<input type="checkbox"/> Carcinoma of the Colon	_____	<input type="checkbox"/> Pregnant (Due Date)	_____
<input type="checkbox"/> Cardiac Condition	_____	<input type="checkbox"/> Rectal/Colon Surgery	_____
<input type="checkbox"/> Crohns Disease	_____	Type	_____
<input type="checkbox"/> Colitis	_____	<input type="checkbox"/> Renal Insufficiencies	_____
<input type="checkbox"/> Dialysis Patient	_____		

Have you taken medications that may weaken the intestinal walls? Yes No

Are you now taking medications that weaken the intestinal walls? Yes No

Taking medications (Please list all below.)

Comments: _____

STATEMENT

I have not been diagnosed with any contraindications for colon irrigation. (See *** above.) When requested to, I will bring with me all prescribed drugs and all natural remedies I am now or have been taking recently. If necessary, I will bring a relative or friend to assist me with wheelchair, mounting and dismounting, and such tasks as dressing, undressing, and inserting the disposable rectal tube during colon hydrotherapy sessions. I am aware that colon hydrotherapists do not claim to cure or treat any condition or disease, are not physicians and, therefore, do not insert rectal irrigation and enema devices, nor do they diagnose or prescribe drugs or issue medical orders for health services. I am aware that adverse events; such as perforation, injury and illness have been alleged and claimed with the use of colon irrigation and enema devices and that I am responsible for my own insertion. If I experience resistance during the insertion, I will immediately stop my colon irrigation session. If during the session I experience discomfort or pain, I am responsible for immediately stopping my session.

CLIENT SIGNATURE: X _____ Date: ___/___/___

(For parent-dependent clients 18 and under, the signature and attendance of the parent or guardian is required for colon hydrotherapy services. A permission form must be signed.)

I have reviewed this form with my client. The physician/chiropractor's written order for each procedure is attached.

Therapist Signature: X _____

HOLISTIC QUESTIONNAIRE FOR COLON HYDROTHERAPY

Name

Email Address

Are you under a doctor's care? Y N If so, please explain:

Doctor's Name

Phone

Major Physical Complaints

Are you pregnant? Y N If so, what trimester?

List all medications and supplements you now take regularly, including over-the-counter:

Are you under a lot of stress? Y N Pinpoint:

List all known allergies:

How many bowel movements per day do you usually have?

Do you strain to have a bowel movement? Y N

Do you use a stool softener or laxative? Y N Herbal laxative? Y N Suppository? Y N

Do you have hemorrhoids or other rectal problems? Y N

Have you ever had any rectal bleeding? Y N If so, when?

Have you ever had bleeding from any other bodily orifices (openings)? Y N

If so, please explain:

Have you ever had a barium enema? Y N If so, when?

What would you like to receive from this appointment for colon hydrotherapy?

ABSOLUTELY NO SEXUAL ACTIVITY PERMITTED!

Signature (Required)

Date

FOR OFFICE USE ONLY

Patient/Client

Date of Assessment

Consultant Signature

"The Forgotten Ninth Amendment,"
by Bennet Patterson, of the Texas Bar (1955)

"Individual freedom, and the recognition and development of the spiritual nature of mankind are the essence of democracy; indeed, they are the essence of life itself. There is no clause in the Constitution, except the Ninth Amendment, which makes a declaration of the sovereignty and dignity of the individual."

"A just government protects all in their liberty of choice.." (George Washington)

NOTICE AND DECLARATION OF NINTH AMENDMENT RIGHTS

"The enumeration in the Constitution of certain rights shall not be construed to deny or disparage others retained by the people."

REQUEST FOR ADVICE AND/OR HELP

NAME (PLEASE PRINT)

AGE

OCCUPATION

REFERRED BY

I, the undersigned, hereby declare the following natural and God-given rights as retained by the people, under the Ninth Amendment to the Constitution of the United States of America, and which rights I reserve to myself as follows:

I reserve the right to seek or ask advice, counsel, information, recommendations, evaluations, assessments, test(s) and/or care, regimens, modalities or treatments from ANY person of my choice, regardless of state sanctions, for any reason or purpose I so desire.

I reserve the right to select or reject ANY individual as my personal advisor, minister, facilitator, doctor, or health care provider whether that individual is a physician, chiropractor, druggist, nurse, nutritionist, herbalist, naturopath, therapist, teacher, practitioner, priest, pastor, relative, friend, or anyone from the general citizenry who has or has not any known formal training or claimed knowledge, education, insights, qualification or credentials.

I reserve this right of freedom of choice in matters pertaining to my spiritual, mental and physical well-being. I reserve this right in the most liberal way. My freedom, with regard to my personal life, circumstances, well-being and the decisions I make, include the right to choose my own religion, associates, obtain, purchase, and use any treatment, technique, regimen, process, modality, herb, drug, food, diet, medicine, or health product for any health condition I have, whether determined by me, a physician, therapist, layman, or anyone of my choice. I do not relinquish these rights to others.

The enumeration of these rights in this declaration shall not be construed to deny or disparage others retained by me, or my right to amend this declaration at any time. I am herewith filing this declaration to uphold my rights. In this regard, the holder of this document is authorized to deliver copies of this declaration to anyone if such a need were to present itself.

CONSTRUCTIVE NOTICE: Notice is hereby given to any person or persons who receive a copy of this declaration and who, acting under color of any law, intentionally interfere(s) with the free exercise of the rights reserved to me under the Ninth Amendment, as enumerated in this document, thus violating Title 42, U.S.C. 1983, et seq., and Title 18, Section 241.

Signature (Required)

Date

Social Security Number

Driver's License or State I.D. Number

Patient/Client

FOR OFFICE USE ONLY

Date of Assessment

Consultant Signature

WELCOME TO NATURAL HEALTH ASSOCIATES, LLC.

Here is how you can help us to help you. Take a few moments to fill out completely the information below, sign your name and date on the lines indicated.

CLIENT STATEMENT

I understand that this is considered personal counseling and that I will be offered information about general guidelines to better health.

I fully understand that those who counsel me are not medical doctors or practitioners and I am not here for medical/diagnostic purposes or treatment procedures.

I am not on this visit or any subsequent visits as an agent for federal, state, or local agencies or on a mission of entrapment or investigation.

I understand that the services performed by Natural Health Associates, LLC. are at all times restricted to consultation on the subject of the maintenance of the best possible state of health and do not involve the diagnosing, treatment or prescribing of remedies for disease.

Signature (Required) _____ Date _____

IF YOU ARE A FEDERAL, STATE, OR LOCAL AGENT, UPON ENTERING THESE PREMISES, YOU MUST DECLARE SAME, OR UNDER THE BIVENS ACT, ARTICLE 42, BE HELD PERSONALLY AND INDIVIDUALLY LIABLE.

X _____ X _____
Signature (Required) _____ Date _____

Age _____ DOB _____ Sex Male / Female Social Security # _____

Name _____ Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ Fax _____

E-mail _____ Height _____ Weight _____ Blood Type _____ Pulse _____ Blood Pressure _____

Employer _____ Type of Work _____ Driver's License # _____ Exp. Date ____/____

Marital Status (✓) Married Single Widowed Divorced Separated # of Children ____ Ages _____

Name of Husband or Wife _____ Emergency Contact/Phone _____

Who is Responsible for Your Bill: Self Parent Husband or Wife Employer Other

Signature (Required) _____ Date _____

FOR OFFICE USE ONLY

Client Name _____ Assessment Date _____ Consultant Signature _____