AloraCleanse

Enjoy Vibrant Health

New Client Paperwork

Hello!

Here is your paperwork. Please fill it out and bring it with you to your appointment. On the day of your appointment, fasting or juicing is recommended for best results. You may eat lightly if you choose (i.e., yogurt, fruit smoothie, toast, etc.), but do not eat at least 2 hours prior to your appointment. Drink plenty of water and stay hydrated. CALM, natural ionic magnesium, is very helpful for constipation sufferers. We are located at 2040 Hwy 59, Suite I in Mandeville. Don't forget: IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT, WE KINDLY AS THAT YOU NOTIFY OUR OFFICE AT LEAST 48 HOURS IN ADVANCE. We are looking forward to meeting you. You will love your Cleanse! Sincerely, Diane

ALORACLEANSE HOLISTIC HEALTH QUESTIONNAIRE

NAME_____ DATE_____
ADDRESS _____ ZIP CODE _____
PHONE_____(c)_____EMAIL _____
DATE OF BIRTH _____ AGE_____ OCCUPATION _____
HT_____WT_____MALE/FEMALE_____ MARITAL STATUS_____
IF YOU ARE A WOMAN, ARE YOU PREGNANT?_____HOW MANY CHILDREN?_____
HOW DID YOU HEAR ABOUT ALORACLEANSE?_____

Health History

HAVE YOU EVER HAD A COLONIC?_____WHEN_____
OTHER RECENT FORMS OF DETOXES/CLEANSES?_____
ARE YOU UNDER A DOCTOR'S CARE_____ IF SO, PLEASE LIST YOUR CURRENT MEDICAL DIAGNOSIS(ES) _____
DOCTOR'S NAME_____PHONE_____
PLEASE LIST ANY PHYSICAL COMPLAINTS_____
_____
PLEASE LIST ALL SURGERIES _____
_____
LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE TAKING, INCLUDING OVER THE COUNTER DRUGS_____
LIST ALL KNOWN ALLERGIES _____

Digestive Health

ON AVERAGE, HOW OFTEN DO YOU MOVE YOUR BOWELS?_____
DO YOU HAVE TO STRAIN TO MOVE YOUR BOWELS?_____DO YOU USE LAXATIVES?_____
DO YOU HAVE HEMORRHOIDS, BLEEDING, OR OTHER RECTAL PROBLEMS? _____
HAVE YOU EVER HAD A BARIUM ENEMA?_____ IF SO, WHEN?_____

Personal Goals

WHAT WOULD YOU LIKE TO RECEIVE FROM THIS APPOINTMENT? IS THERE ANYTHING SPECIFIC YOU ARE HOPING TO ACHIEVE?_____
_____
WHAT ARE YOUR LONG-TERM HEALTH GOAL(S) ?_____
_____
_____

CANCELLATION POLICY:

We understand that circumstances can and do occasionally arise which would make you unable to attend your scheduled appointment. Our policy requires that you give us **48 hours notice** of any cancellation, at which time, we will be happy to reschedule your appointment. If less than 24 hours is given, you will be required to pay the full amount of the missed appointment. INITIALS_____
I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate a session, any fees for the professional services will be due and payable.

I hereby approve the colon hydrotherapist to touch me in accordance with the procedure. *Note: We do not diagnose or make any attempt to cure or treat any condition. We make no claims or imply any claims to cure or treat any condition. We do not claim that any supplemental material we may speak about will cure any condition, or that it's purpose is to treat any condition. We do not prescribe or treat disease; however, we do attempt to educate you on foods and exercise if it is not contradictory to the recommendations of your primary health care provider or physician.*

CLIENT SIGNATURE_____DATE_____

ALORACLEANSE HEALTH QUESTIONNAIRE CONTINUED

PLEASE TELL US ABOUT YOUR HEALTH. DO YOU OR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

DIGESTIVE	***DIGESTIVE CONT'D***	***OTHER***
( ) Eating under stress (working, driving, etc.)	( ) Constipation OR diarrhea	( ) Body temperature hard to regulate
( ) Bitter, metallic taste in mouth in morning	( ) Mucous Colitis	( ) Waken after asleep, hard time falling back asleep.
( ) Irritable before meals	( ) "Nervous" Stomach	( ) Pain, local such as low back
( ) Faintness when meal is delayed	( ) Stool is very dark in color	( ) Pain, dull all over
( ) White-coated tongue	( ) Lose taste for meals	( ) Poor circulation
( ) Sugar OR alcohol cravings	( ) Excessive appetite	( ) Shortness of breath
( ) Caffeine OR nicotine cravings	( ) Weight gain	( ) Muscle cramps
( ) Bad breath or halitosis	( ) "Shaky" if hungry	( ) Headaches
( ) Always hungry	( ) Vomiting frequently	( ) Dizziness or lightheadedness
( ) Foul smelling gas	( ) Gag easily	( ) Joint stiffness
( ) Stool with foul odor	( ) Nausea	( ) Losing hair (excessive)
( ) Body odor	( ) Blood in stool	( ) Eyelids swollen, puffy
( ) Pressure in pit of stomach	( ) Rectal or anal bleeding	( ) Dry mouth, eyes, nose
( ) Hx of gall bladder problems	( ) Small urine output	( ) Fatigue, often tired
( ) Habit of overeating	( ) Dark colored urine	( ) Insomnia
( ) Habit of under-chewing	( ) Frequent urination	( ) Bruise easily
( ) Difficulty Swallowing	( ) Fatigue relieved by eating	( ) Muscle cramps
( ) Milk products = distress	( ) Ulcer(s)	( ) Hands & feet cold, clammy
( ) Stomach bloating after meals	( ) Gall Stones	( ) Numbness in hands or feet
( ) Sour stomach- frequent	( ) Kidney Stones	***SKIN***
( ) Tension under ribcage	( ) Thyroid problems	( ) Itching skin
( ) Digestion difficult	( ) Anorexia or Bulimia	( ) Skin peeling or cracking
( ) Abdominal pain or cramping	( ) Liver disease	( ) Acne, blemishes, pimples
( ) Gas, excessive	( ) Intestinal parasites	( ) Dry, thin, brittle hair and nails
( ) Reduced appetite	***MOOD/COGNITION***	( ) Skin rashes
( ) Difficult bowel movements	( ) Difficulty remembering	( ) Eczema or Psoriasis
( ) Acidic foods upset stomach	( ) Feeling depressed	***INFECTIONS***
( ) Indigestion after meals	( ) Worried, feeling insecure	( ) Susceptible to colds
( ) Stool is soft, watery	( ) Difficulty concentrating	( ) Strep throat
( ) Disordered eating	( ) Racing thoughts	( ) Mononucleosis
( ) Laxative use, chronic	( ) Preoccupied with thoughts	( ) Tuberculosis
( ) Burning stomach sensations	( ) Irritability	( ) Hepatitis
( ) Burning or itching anus	( ) Anxiety	***( ) ABNORMAL LAB WORK***

PLEASE TELL US ABOUT ANY OTHER ISSUES OR CONCERNS YOU MAY HAVE:

I have honestly answered all questions above and am not intentionally withholding information about my health.

To Determine Your Eligibility for Colon Hydro-Therapy Session

These standards are meant as general guidelines. Because each person has a unique medical history, you should consult your physician to determine if you are healthy enough to undergo colon hydro-therapy. Persons with certain medical conditions (contraindicated conditions) are prohibited from undergoing colon hydro-therapy unless they are given approval from and/or by prescription from their physician. These conditions include the following:

Contraindicated conditions (Not eligible for Colonic)

- Cirrhosis of the Liver
- Kidney Disease
- Pregnancy
- Renal Failure or Renal Insufficiency (Kidney Failure)

Conditions by prescription only

- Anemia: Severe
- Aneurysm
- Carcinoma of the Large Intestine or Rectum
- Cardiac Disease: Severe (e.g. Uncontrolled hypertension or high blood pressure)
- Chron's Disease
- Colitis: Severe (Ischemic Colitis and Ulcerative Colitis)
- Congestive Heart Failure (e.g. Organic Valve Disease)
- Diverticulitis: Sever or Acute
- Epilepsy/Seizures
- Fissures/Fistulas
- GI Hemorrhage/Perforation
- Hemorrhoids (when excessive bleeding is present)
- Hernia: Incarcerated Abdominal
- Prostatitis
- Surgery: Recent Abdominal (6 months or earlier post-surgery)
- Tumors of the Large Intestine or Rectum

My signature verifies that: (check one of the following statements)

- ○ I have read the above and do not have any of the contraindicated conditions.
  OR
- ○ I may have or do have a condition that requires me to have a prescription for the colonic treatment I have scheduled. I understand that my therapy will be rescheduled if I am unable to meet the above terms and conditions.

_____ _____

Client Name (Signature) Date

_____

Client Name (Printed)

SIGNATURE_____DATE_____

AloraCleanse Credit Card Authorization

We kindly ask for 48 hours notice if you find you cannot make your appointment. Last minute cancellations (less than a full 24 hours before your designated appointment) and/or no calls, no shows will be charged in the amount of the therapy session missed. In order to provide you with the highest quality service, we do not overbook our schedule so we can spend one-on-one time with you.

Please complete the following information. This information will be kept confidential in your file and used only if charges are incurred for missed appointments or late cancellations.
Established clients: please initial here if you would like to authorize AloraCleanse to continue to charge your account for special supplement orders_____.

Name of Cardholder: (as it appears on credit card)_____

Billing Zip Code: _____

☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: (month/year) _____

*I certify that I am an authorized user of this credit card. I authorize AloraCleanse, LLC to charge the credit card indicated on this authorization form according to the terms indicated above. I promise to pay all charges in accordance with my credit card company agreement. I understand that fees are due and payable at the time of service, and there are no refunds for services or products provided by AloraCleanse, LLC.

Signature of Cardholder:_____