

Soothing Solutions
207 W. Alameda Ave. Burbank, Ca 91502
(818)848-9886

Please PRINT legibly on all 3 pages **Today's Date:** _____
Last Name: _____ **First Name** _____
Address: _____ **Suite/Apt #:** _____
City _____ **State** _____ **Zip Code** _____
Day Phone: _____ **Cell #** _____ **Evening Phone:** _____
E-mail Address: _____ **Occupation:** _____
Age ____ **Birth day** _____ **Sex:** M F **Marital Status:** S M D W **# of Children** ____
Name of Emergency Contact: _____ **Relationship?** _____
Emergency Contact Phone Number(s):
Daytime: _____ **Cell** _____ **Evening:** _____

Yes, your credit card # on file is a requirement.

This will allow you to call in to book future appointments. Your card will be used ONLY in the case of a "no show". If you need to cancel appointments please call by the day previous to your appointment in order to avoid the \$25.00 "no show" fee. The \$25.00 fee will only be charged if you do not call to cancel an appointment that you do not show up for. We ask for at least a 12 hour advance cancellation.

Visa/MC _____ **Exp. date** _____
Name on Card _____

How did you hear about *Soothing Solutions*? (Check One)

- Yellow Pages Magazine Newspaper Health Expo Television Radio
 Internet Friend _____ friend's name-(they will get \$5 credit)

Which service are you here for today? (Check all applicable services.)

- Colon Hydrotherapy Float Tank Infrared Sauna ISqueeze Foot Massage
 Ion Detox Footbath Detox Plan B.E.S.T. Release Therapy Chi Machine Other
Do you plan on trying any other services? Y N Which ones? _____

Do you now, or have you ever had any of the following? (Check all applicable)

If you have any of the you should check with your doctor before doing colonic.

- | | |
|---|---|
| <input type="checkbox"/> Severe Cardiac Disease | <input type="checkbox"/> Abdominal Hernia |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Carcinoma of the Colon |
| <input type="checkbox"/> Organic Valve Disease | <input type="checkbox"/> Cirrhosis of the liver |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Severe Hemorrhoids (bleeding, open & infected) |
| <input type="checkbox"/> Severe Anemia | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Colon Surgery (within 6 mo.) | <input type="checkbox"/> Renal Insufficiency (Kidney) |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> Fissures and/or fistulas | <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> Abdominal Surgery (within 6 mo.) | |

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(Circle all that apply.)

Is it possible that you may be pregnant? Y N

Are your periods regular? Y N Do you suffer from PMS? Y N

Are you currently under a Doctor's care? Y N

If yes, please explain: _____

Do you now have any of the following? (circle all that apply)

Headaches Fainting spells Insomnia

History of seizures Loss of weight Fatigue

Dizziness Severe Depression Claustrophobia

Double/blurred vision Severe Mood Swings Fear of the dark

Please list year and type of any **MAJOR** illnesses and operations:

Please list known allergies _____

Are you vegetarian? Y N

Do you eat red meat? Y N Do you eat chicken? Y N Do you eat/drink dairy products? Y N

Major physical complaints?

Any abdominal surgeries? Y N What kind, and how long ago? _____

Have you ever had x-rays of your colon? _____ Why _____ Results _____

Have you ever had a colonoscopy? Y N If yes, when? _____ Results: _____

Have you taken antibiotics for an infection in the past year? Y N

Do you have hemorrhoids? Y N

If so, are they a bother to you now? Y N

Do you have a history of Colon Cancer in your family? Y N

Have you ever had a colon hydrotherapy session? Y N

If so, **how long ago** _____ and where? _____

Do you give yourself enemas? Y N

If Yes, how often? Weekly Monthly Annually

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Do you take laxatives? Y N **How often?** Daily 3 x/week Weekly Monthly Occasionally
How long have you been taking them? __ weeks __ months __ years
What type of laxative? Herbal Over the Counter Prescription

How often do you have a bowel movement? 1 x Week 2 x Week 3 x Week
1 x Day 2 x Day 3x Day 4 x Day OTHER: _____

What do you hope to accomplish with colonics?

To the Client:

AGREEMENT: "Soothing Solutions" does not provide medical services of any kind. Any procedures administered by this office are a non-medical in nature. We do not diagnose, treat or cure any disease or physical or mental human ailment or condition of any kind. Any medication or other supplementation prescribed by your physician should be continued. Any medical complaints or request for diagnosis, prescription or treatment of human ailments should be referred to your licensed physician. You should consult your doctor before beginning any new health program. Please call within AT LEAST 12 hours if you must break an appointment.

- To respect other clients time and ours, be advised that if you are more than 15 minutes late to your appointment, it **may** need to be cancelled.
- Please be advised that the discount package plans expire 4 months from the original date of purchase, and should be used within this time and are not to be shared. Any requests for refunds for unused appointments need to be within a week of purchase.
- There will be a \$25.00 fee for any returned check. If you do not remit payment within 10 days from the original date of service, there will be an additional \$25.00 fee. After that, a \$25.00 fee will be added again for each 30 days of non-payment.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment for the full scheduled appointment.

I have chosen to have therapeutic treatments by "Soothing Solutions". I understand that no specific therapeutic claim is implied or made by "Soothing Solutions" in administering these applications. I understand that if I have any doubt about doing any of the services offered by "Soothing Solutions" I should consult with my doctor first, and will not hold "Soothing Solutions" or it's employees responsible for any unforeseen side effects, or any injuries due to treatments, accidents or any slips or falls.

I have read and understand and agree to the above statements.
All information is true to the best of my knowledge.

Client's Signature: _____ **Date:** _____