RIVER OF LIFE COLON HYDROTHERAPY AND NUTRITIONAL CENTER, L.L.C.
2442 25TH AVE.
FOREST GROVE, OREGON 97116
1-503-430-7868

NAME:_____**PHONE:(H)**_____
ADDRESS:_____**(B)**_____
CITY:_____ **STATE:**_____**ZIP:**_____**EMAIL:** _____

HEIGHT: _____ **WEIGHT:**_____ **SEX: M F AGE**_____ **RIGHT OR LEFT HANDED?**_____
BIRTHDATE:_____ **RIVER OF LIFE WANTS TO CELEBRATE YOU!! 10% OFF DURING THE WEEK OF YOUR BIRTHDAY!!**

OCCUPATION:_____

EMERGENCY CONTACT AND PHONE:_____

REASON FOR THE VISIT:_____**ALL KNOWN ALLERGIES:**_____
_____
WOMEN ONLY: PREGNANT? Y N WHICH TRIMESTER?_____
HOW MANY CHILDREN ? _____ **HAVE YOU EVER HAD A CAESAREAN SECTION? Y N**
DATE OF LAST MENSTRUAL PERIOD? _____

HOW MUCH WATER DO YOU DRINK PER DAY? PLEASE, BE ACCURATE!_____

HOW OFTEN DO YOU HAVE A BM?_____ **DID YOU HAVE ONE TODAY? Y N**
DO YOU HAVE TO STRAIN? Y N DO YOU HAVE TO USE LAXATIVES? Y N USE ENEMAS? Y N
DO YOU USE SUPPOSITORIES? Y N HAVE YOU EVER HAD A BARIUM ENEMA? Y N
ANY RECTAL SURGERY? Y N HAVE YOU EVER HAD A COLONIC BEFORE? Y N
IF YES, WHEN WAS YOUR LAST SESSION? _____ **ANY OTHER RECTAL PROBLEMS? Y N**
IF YES, PLEASE EXPLAIN:_____**ANY HEMORRHOIDS? Y N**

ARE YOU UNDER A DOCTOR'S CARE? Y N PLEASE, EXPLAIN:_____
_____
DOCTOR'S NAME:_____**PHONE:**_____
HAVE YOU EVER HAD A COLONOSCOPY? Y N IF SO, WHEN?_____

PLEASE LIST ALL SUPPLEMENTS, OVER-THE-COUNTER MEDS, AND PRESCRIPTION DRUGS YOU TAKE REGULARLY:_____
_____**DO YOU SMOKE? Y N**

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DO YOU HAVE ANY INFECTIONS IN YOUR BODY AT THE PRESENT? Y N WHERE?_____
HAVE YOU EVER USED ANTIBIOTICS? Y N WHEN AND WHAT FOR?_____
_____
COVID: HAVE YOU HAD COVID? Y N DO YOU KNOW OF ANYONE, RIGHT NOW, WHO HAS COVID? Y N HAVE YOU HAD ANY COVID IMMUNIZATIONS?_____

LIST ANY SURGERIES YOU HAVE HAD IN THE LAST SIX MONTHS:_____
_____ANY COLON SURGERY AT ALL? Y N WHEN?_____

EATING HABITS

WHAT FOODS DO YOU CRAVE? (SUGAR, SALT, PROTEIN, CARBOHYDRATES, ETC.) :_____
_____
HOW MANY MEALS DO YOU EAT A DAY?_____DO YOU EAT BREAKFAST? Y N SNACKS? Y N
DO YOU HAVE A REACTION IF MEALS ARE DELAYED? Y N WHAT IS IT?_____
_____
PLEASE INDICATE THE NUMBER OF SERVINGS OF EACH OF THESE FOODS/LIQUID GROUPS YOU HAVE CONSUMED IN THE LAST 24 HOURS AND PUT A CIRCLE AROUND EACH FOOD/ LIQUID GROUP YOU HAVE CONSUMED IN THE LAST YEAR:

_____FLOUR	_____DAIRY PRODUCTS	_____WATER
_____SUGAR	_____ ALL CHEESE	_____ MILK
_____PASTA	_____BREAD	_____COFFEE
_____RICE	_____WHOLE GRAINS	_____CAFFEINATED TEA
_____POTATOES	_____FRUIT	_____ HERB TEA
_____BEANS	_____TOMATOES	_____ CARBONATED BEVERAGES
_____RED MEAT	_____ORANGES/TANGERINES	_____SPORTS DRINKS
_____CHICKEN	_____RAW GREENS	_____ALCOHOL
_____TURKEY	_____COOKED GREENS	_____FATS AND OILS
_____FISH	_____ ORANGE/YELLOW VEGETABLES____	CHOCOLATE
_____TOFU	_____PROCESSED/PACKAGED FOODS____	ALL CANDY

HEALTH CONCERNS

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS IN THE PAST? Y OR N PUT A CIRCLE AROUND EACH ONE THAT IS ACTIVE NOW IN YOUR BODY.

Y N	Y N	Y N
□ □ ABDOMINAL HERNIA	□ □ CARDIAC DISEASE, SEVERE	□ □ HEART ATTACK, RECENT
□ □ ACNE	□ □ CIRRHOSIS OF THE LIVER	
□ □ ACUTE ABDOMINAL PAIN	□ □ COLD SORES	□ □ HEMORRHOIDS, BLEEDING
□ □ AIDS/HIV/HEP-C	□ □ ACUTE COLITIS, ULCERATED	
□ □ ALCOHOLIC/DRINK ALCOHOL	□ □ CONGESTIVE HEART FAILURE	□ □ INSOMNIA/DIZZY/ SLEEP PROBLEMS
□ □ ALLERGIES, DRUG REACTION	□ □ COLON, LAZY/SPASTIC OR IRRITABLE BOWEL (IBS)	□ □ KIDNEY DISEASE
□ □ ANEMIA, SEVERE		
□ □ ANEURYSM	□ □ CONSTIPATION/DIARRHEA	□ □ LIVER DISEASE

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Y	N		Y	N		Y	N	
□	□	ANOREXIA/BULIMIA	□	□	CROHN'S DISEASE	□	□	LUNG DISORDERS
□	□	ARTHRITIS	□	□	DEPRESSION/ANXIETY	□	□	PARASITES
□	□	ASTHMA	□	□	PRE-DIABETES/DIABETES	□	□	MUSCLE/JOINT PAIN & STIFFNESS
□	□	BACK PROBLEMS/PAIN	□	□	DIAGNOSTIC/SURGICAL PREP	□	□	PACEMAKER
□	□	BAD BREATH/BODY ODOR	□	□	DIGESTIVE PROBLEMS	□	□	PHYSICAL DEBILITATION
□	□	BIPOLAR DISEASE	□	□	DIVERTICULOSIS, SEVERE	□	□	SINUS PROBLEMS
□	□	BLADDER DISORDERS	□	□	ALL DRUG ADDICTION	□	□	SKIN PROBLEMS
□	□	BLADDER INFECTIONS	□	□	EARACHE/EAR PROBLEMS	□	□	STROKE
□	□	HIGH/LOW BLOOD PRESSURE, UNCONTROLLED	□	□	EDEMA/SWELLING	□	□	ULCER, STOMACH
□	□	BRONCHITIS/CHRONIC COUGH	□	□	EPILEPSY/SEIZURES	□	□	VOMITING
□	□	BURPING/INDIGESTION	□	□	FISSURES/FISTULAS	□	□	WEIGHT PROBLEM
□	□	CANCER	□	□	FREQUENT COLDS	□	□	OVERGROWTH OF YEAST
□	□	CHEMO/RADIATION TREATMENT	□	□	G.I. BLEEDING			
			□	□	HEADACHES/MIGRAINES			
			□	□	HEARTBURN/ACID REFLUX			

BECAUSE I AM AWARE OF ANY EXISTING PHYSICAL CONDITIONS THAT I MAY HAVE, I HAVE HONESTLY ANSWERED ALL OF THE QUESTIONS ON PAGE 2, UNDER HEALTH CONCERNS AND AM NOT INTENTIONALLY WITHHOLDING INFORMATION ABOUT MY HEALTH. I WILL INFORM THE RIVER OF LIFE OF ANY CHANGES IN MY PHYSICAL HEALTH. I AM AGREEING TO THE OFFICE POLICIES AND PROCEDURES OF THE RIVER OF LIFE COLON HYDROTHERAPY AND NUTRITIONAL CENTER, L.L.C.

DATE:_____
CLIENT SIGNATURE:_____

COLON HYDROTHERAPY IS PART OF A HEALTHY LIFESTYLE. THE PURPOSE OF THE RIVER OF LIFE COLON HYDROTHERAPY AND NUTRITIONAL CENTER, L.L.C. IS TO PROVIDE SERVICES, PRODUCTS, AND OFFER INFORMATION TO CLIENTS. MY SERVICE, PRODUCTS, AND INFORMATION ARE FOR VOCATIONAL AND ADVOCATIONAL SELF-IMPROVEMENT. THIS BUSINESS DOES NOT INTEND TO TREAT, DIAGNOSE, PRESCRIBE OR CURE. ALL PROCEDURES AND PRODUCTS ARE DIRECTED TOWARDS THE ESTABLISHMENT OF THIS GOAL AND MAY OFFER SERVICES AND NUTRITIONAL INFORMATION TO HELP YOU COOPERATE WITH YOUR DOCTOR IN YOUR MUTUAL PLAN OF HEALTH BUILDING. IN THE EVENT YOU USE THIS INFORMATION WITHOUT YOUR DOCTOR'S APPROVAL, YOU ARE PRESCRIBING FOR YOURSELF WHICH IS YOUR CONSTITUTIONAL RIGHT.

DATE:_____
CLIENT SIGNATURE:_____

I HAVE BEEN INFORMED AND AGREE TO SELF-INSERTION AND SELF-RETRACTION OF THE SPECULUM.

DATE:_____
CLIENT SIGNATURE:_____

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ALL DISCOUNTS, EQUIPMENT, PRODUCTS, SERVICES, AND SUPPLEMENTS ARE NON-REFUNDABLE. I TAKE FULL RESPONSIBILITY FOR ANY PRODUCTS I PURCHASE

DATE:_____
CLIENT SIGNATURE:_____

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.

I HAVE READ THE NOTICE ABOVE AND DECLARE THAT I AM NOT AN AGENT.

PLEASE READ BELOW CAREFULLY BEFORE SIGNING:

DATE:_____
CLIENT SIGNATURE:_____

CANCELLATION POLICY: A FULL PAYMENT IS DUE FOR ANY CANCELLATION WITHIN 24 HOURS.

DATE:_____
CLIENT SIGNATURE:_____

SOME NOTES TO REMEMBER:

1) **DO NOT EAT, AT LEAST, 4 HOURS BEFORE YOU COME.**
2) **BEFORE YOUR FIRST VISIT, PLEASE BATHE YOURSELF EXTREMELY WELL.**
3) **FOR YOUR FIRST COLONIC, EXPECT TO BE HERE 2 HOURS, SO SCHEDULE ACCORDINGLY.**
4) **ALWAYS KEEP AN EXTRA SET OF CLOTHES IN YOUR CAR.**
5) **PHOTO I.D. REQUIRED, WITHOUT IT, WE CANNOT PROCEED FORWARD.**
6) **NO CHILDREN AND PETS ALLOWED.**
7) **ARE YOU ALLERGIC TO LATEX, PAPER, MATERIAL, PLASTIC, OR SOAP? YES NO**
8) **A MAN WOULD NEED TO BRING A WOMAN WITH HIM, LIKE A WIFE, SISTER, GIRLFRIEND, ETC. A WOMAN ALONE IS FINE.**
9) **PLEASE, GET YOUR QUESTIONNAIRE BACK TO ME BEFORE YOUR FIRST APPOINTMENT, MAIL BACK TO THE ADDRESS BELOW. WITHOUT IT, WE CANNOT PROCEED FORWARD.**
10) **IN ORDER TO HAVE COLONICS, YOU MUST ATTEND BOTH SEMINARS I AND II.**

HOW DID YOU HEAR ABOUT THE RIVER OF LIFE? SEMINAR'S I & II ☐ WEBSITE ☐ FRIEND/RELATIVE ☐ FARMER'S MARKET ☐ PHONE BOOK ☐ NEWSPAPER ☐ ON THE BACK OF A GROCERY MARKET RECEIPT ☐ OTHER ☐.

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