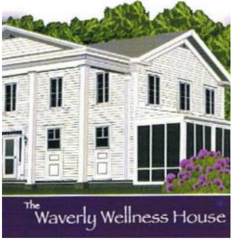


Waverly Wellness House

Donna Florimonte R.N.

1102 Lily Lake Road
PO Box 255
Waverly, PA 18471
Phone: (570) 563-2565

Date: _________________________________ **Have you ever been here before?** Yes No

Date of Birth: _________________ **Age:** ____________ **Home phone:** (_____) ________________________

Name: ____ **Cell phone:** (_____) ________________________

Street Address: ____

City, State, ZIP: ____

Email: ____

Occupation: _______________________________ **Business Phone:** (_____) _____________________

Male / Female **Height** _______________ **Weight** _______________

Referred By: ____________________________________

Do you have a pacemaker? Yes No **Do you have uncontrolled hypertension?** Yes No

Have you ever had any of the following?

____ Far Infra-Red Sauna treatments ____ Massage ____ Manual / Electro-Lymphatic treatments

____ Colon Hydro Therapy ____ Reflexology ____ Essential Oils

____ Chiropractic Care ____ Muscle Testing ____ Neuro Emotional Technique

Colon Hydro Therapy only

I, ______________________________, have been informed and fully understand that Colon Hydro Therapy “Colonics” has been presented to me as a hygienic method of cleansing the colon.

Colonic has NOT been presented to me as a treatment or cure for any illness or specific disease, or with any guarantee to heal any disease. Whether or not I participate in this program is my decision, which I have chosen as a positive action for my personal preventative health care.

Everyone should take a good replenishment of acidophilus culture. I recommend taking this culture regardless if you have been on colonic treatments or not. However, it is strongly recommended it to be taken after the colonic treatments.

*** WE ARE NOT PRACTICING MEDICINE, BUT WE ARE A SERVICE TO YOUR DOCTOR. ***

Signature: ____ **Date:** ________________________________

Name: ____ **Date:** __________________________________

IF YOU EXPERIENCE ANY OF THE FOLLOWING, PLEASE CHECK:

Arthritis ___ **Asthma** ___ **Colitis** ___ **Diabetes** ___ **Diverticulitis** ___ **Ulcers** ___ **Kidney Problems** ___

Fatigue ___ **High Blood Pressure** ___ **Hemorrhoids** ___ **Constipation** ___ **Water Restriction** ___

Bad Breath ___ **Headaches** ___ **Indigestion** ___ **Other** ____

Allergies __________________________________ **Cancer/Type** ____

Surgeries/explain ____

DO YOU USE ANY OF THE FOLLOWING?

Alcohol ________**drinks / week** **Tobacco** _____ **packs/day**

OTC Medications ____

____

Prescriptions: ____

____

____

Are you under a doctor's care/explain: ____

____

____

Doctor's name/phone number ____

TYPICAL DAY FOR FOOD including drinks

What do you usually eat?

Breakfast: ____

Lunch: ____

Dinner: ____

Do you experience digestive distress before, during or after you eat a meal?..Yes No

If so, is this related to a particular type of food?..Yes No

If so, what type: ____

Do you feel that your current weight is a problem?...Yes No

Do you feel that you have a problem with food?..Yes No

Name: ____ **Date:** __________________________________

DIET AND NUTRITION

How often do you use the following? (1-Daily, 2-Weekly, 3-Occasionally, 4-Never)					
Red Meat	*1 2 3 4*	*Fruits/Veggies*	*1 2 3 4*	*Fast Foods*	*1 2 3 4*
Refined Sugar	*1 2 3 4*	*White Flour*	*1 2 3 4*	*Fried Foods*	*1 2 3 4*
Dairy Foods	*1 2 3 4*	*Soda*	*1 2 3 4*	*Alcohol*	*1 2 3 4*
Snack Foods	*1 2 3 4*	*Salted Foods*	*1 2 3 4*	*NutraSweet*	*1 2 3 4*
Coffee	*1 2 3 4 Cups day ______*	*Tea*	*1 2 3 4 Cups day ______*	*Tobacco*	*Amount ________*
How much water do you drink per day in ounces? __________		*What kind of water do you drink? ___________________*			
List any Nutritional Supplements (with amounts) you are now taking:					

FOOD CHOICES

Do you use organic foods whenever possible? Yes No — Are you a vegetarian? Yes No

Do you eat meat, i.e. beef, chicken, lamb, etc. Yes No

Do you buy hormone/antibiotic free meats? Yes No

Do you drink milk? Yes No

Circle all that apply to your Dairy Consumption: Raw Pasteurized Organic Goat Dairy

Circle products that you consume: Soy milk Rice milk Almond milk Hemp milk Other: _________________

Do you eat nuts or seeds? Yes No — What Type? _____________________________

Do you use spices? Yes No — Are they organic? Yes No

Circle the type of spices that you consume: Fresh spices Dried Spices Jarred Spices Bulk Spices Organic Spices

Do you PREFER to home cook your food or go out to a restaurant? Restaurants Home

Do you eat more at restaurants or at home? Restaurants Home

When you go to a restaurant, do you prefer menu style or buffet? Menu Buffet

Would you like to learn how to prepare foods at low temperatures that are fresh and preserve enzymes? Yes No

What types of bread do you eat? ____

What types of pasta do you eat? ____

GENERAL LIFESTYLE

How much sleep do you get on average? ______ hours per night — Do you feel rested?..............................Yes No

How much exercise do you get?
Exercise _______ min per day _______ days per week Type(s):____

Do you experience stress: in your relationships ___, at work ___, with finances ___, in health ___, with home ___, in trying to have fun ___, in being happy ___, other ____

How often do your bowels eliminate?

What is your energy like?

Other current health concerns not previously mentioned:
____
____
____
____

Medical History

Name: ______________________ Date: ______________

Please circle/check mark all that apply. Put a "P" next to the circle if it is a past medical condition.

Also, please remember to note any medical condition not mentioned on this sheet under other.

Senses	Sight	Hearing	Smell	Taste	Touch

Skin

Boils	Fungal Infection (Athlete's Foot)		Herpes	
Warts	Eczema	Hives	Moles	Psoriasis

Respiratory System	Bronchitis (490)	Sinusitis (J32.9)	Asthma (J45.998)	Emphysema (J43.9)
Allergies (995.3) ______________________				

Endocrine	Ovarian Cyst (N83.0)	Fibroids	PCOS (E28.2)	Infertility (♂ N46.9 / ♀ N97.9)
Ovaries	Uterus	PMS (N94.3)	Menopause	
(Hypo)Thyroid (E03.9)	Adrenals (E27.9)	Testicles	Prostatitis (N41.9)	Other ________
Diabetes	Type 1 (E10.9)	Type 2 (E11.9)	Hyperglycemia (R73.9)	Hypoglycemia (E16.2)

Immune

Bacterial	Viral	Colds	Flus	Lyme's Disease (A69.20)
Autoimmune	Rheum Arthritis	Epstein Barr (B27.90)	Chronic Fatigue (R53.82)	

Musculoskeletal	Osteopenia (M85.80)	Arthralgia (719.4)	Unspecified	Unspecified
Sprain/Strains	Osteoporosis (M81.0)	Carpal Tunnel (G56.00)	Joint Pain(M25.50)	Osteoarthritis (M19.90)
Herniated Disc (722.2)	Neck Pain (M54.2)	Low Back Pain (M54.5)	Other Pain/Injury ____________________	

Nervous System

Multiple Sclerosis	Parkinson's	Bell's Palsy	Stroke	Spinal Cord Injury
HA 784.0) /Migraine (346)	Numbness	Tingling	Idiopathic pain	

Digestion

Indigestion (K31.9)	Constipation (K59.00)	Diarrhea (R19.7)	Acid reflux (K21.9)	Ulcers (K25.9)
Hx Appendicitis (v12.79)	IBS (K58.94)	Ulcer. Colitis (K51.90)	Hepatitis (573.3)	Gallstones (574)
Food Allergies (995.3): ______________________			Gall Bl removed (051)	Gall Bladder Dz (K82.9)

Circulatory	Blood Clot (I82.91)			
Anemia (D64.9)	Cardiovascular Dz (I25.10)	Atherosclerosis (I70.90)	High (R03.0)/Low (I95.9) Blood Pressure	
Vericose Veins (I83.10)	Heart Disease (I51.9)	Heart Attack (412)	Edema (R60.9)	High Cholesterol (E78.0)

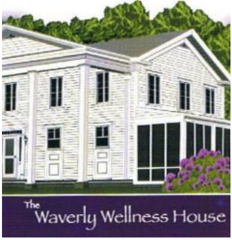
Cancer

Breast	Ovarian	Testicle	Thyroid	Lung
Blood	Bone	Colon	Bladder	

Stress	Chronic Stress (F33.9)	Acute Stress Rxn (F43.0)		State of Stress & Shock (R45.7)
Anxiety (F41.1)	Depression 1 (F32.0)	Lack of Sleep (G47.9)	Phobias (F40.9)	Nightmares (F51.5)

Viamin / Mineral Deficiency		Dehydration (86.0)	Hypervitaminosis (T45.2X4A)	
A (E50.9)	B1 Thiamine (E51.9)	B2 Riboflavin (E53.0)	B3 Niacin (E53.9)	B5 Panthenic Acid (E53.9)
B6 (E53.1)	B9 Folic Acid (E53.9)	B11 Biotin (E53.9)	B12 (E53.9)	C (E54)
D (E55.9)	E (2E56.0)	Fatty Acid Ox. Dis (E63.0)	K (E56.1)	Unspecified (E63.9)

OTHER: ____



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ATTENDANCE POLICY
RETURNED CHECK FEE POLICY

Waverly Wellness House (WWH) is in the business of treating clients who require cleansing and detoxification of their bodies. WWH cannot help you or someone else if you do not show for or cancel your appointment without advanced notice. Therefore, by signing below, you agree to provide 24 hours advance notice in the event the appointment(s) have to be canceled or changed.

If I, the undersigned, do not show up for the appointment, or provide sufficient notification, I agree to pay the full charge for the service, not just for the inconvenience it has caused, but also the loss of income to our therapist who comes in for your appointment. Appointments cancelled less than 24 hours in advance will be charged 50% of the cost of the service. WWH understands that in certain incidences, this is not possible because of emergencies and therefore the charges may be waived at the discretion of management.

Waverly Wellness House accepts cash, credit cards and personal checks for services provided and products purchased. In the event that your personal check is returned by your bank unpaid, you will be assessed a $ 25.00 returned check fee.

______________________	______________________
Client	**Witness**
______________________	______________________
Date	**Date**