COLON HYDRO-THERAPY INTAKE FORM

Before filling out this form, please complete the Contraindications Questionnaire.

NOTE: If you have a Contraindicated Condition, please take your paperwork to the receptionist or therapist to discuss if you should complete the procedure.

Please complete the following questions carefully. All data is confidential to ensure your privacy.

Name _____

Address _____

City _____ State _____ Zip _____

Occupation _____ Employer _____

Birth date _____ Height _____ Weight _____ Female _____ Male _____

Marital Status Single _____ Domestic partnership _____ Divorced _____

Widowed _____ Married _____ # children _____

Home # _____ Work # _____ Cell # _____

Email address _____ May we contact you at this address? _____

Emergency Contact _____ Phone # _____

How did you learn about our services? Who may we thank for the referral? Doctor/Practitioner _____

Print Ad _____ Internet _____ Yellow Pgs. _____ Personal referral _____ Other *(describe below)*

_____

Medical care: Date of most recent visit to a Primary Care Physician (PCP) _____

Are you currently receiving healthcare by a MD/ND/Homeopath doctor(s)? _____

If so, please explain: *(Blood sugar or Thyroid issues, High blood pressure or cholesterol issues, etc.)* _____

_____

_____

Do you have a prescription for this visit? _____ If yes, do we have a copy on file? _____ If yes, date: _____

Do your records need to be shared with other? _____ If yes, whom? _____

Is colon hydro-therapy part of a protocol that a doctor or other healthcare professional has referred or prescribed for you? _____

_____

Doctor's name _____ When? _____

Type of doctor PCP Gastrointestinal doctor Proctologist Other _____

Allergies: *List all known* _____

_____

Health concerns: *List top* _____

_____

Parasites: Do you know you have parasites? _____ If yes, describe: _____

Back issues: Do you have any problems/pain in the lower back (lumbar region)? _____

If yes, describe: _____

Abdominal area surgeries: *Circle all that apply.* C-Section Gallbladder Gastric Bypass

Hysterectomy Lap Band Vaginal Mesh Other _____

If yes to any of the above, do you feel that you have had a change in bowel habits? _____

Colonic History: Have you ever had a colonic before? _____ If so, when ? _____

If yes, please describe your experience: _____

Type of device used (Colonic system) *Circle all that apply.* Closed Open Gravity Not sure

Other forms of cleansing you are using or have used: _____

Digestion: How is your digestion? *Circle all that apply.*

Adequate Poor Acid reflux Bloating Burning/pain in stomach Indigestion Ulcers

If other complaints described _____

Have you seen a doctor about them? _____

Medications & supplements: List all you now take regularly including over the counter _____

Do you take digestive aids? _____ If yes, describe: _____

When was the most recent time you took antibiotics? _____ Why? _____

Bowel Habits: How often do you have bowel movements? 3 per day 2 per day 1 per day skips days

How are your bowel eliminations normally? *(Circle the best response)* Requires straining Effortless

When? Only after eating Varies (describe)

Amount: normal too little too large **Consistency:** normal too hard very soft diarrhea

Color: brown black whitish greenish **Other:** lots of mucus lots of gas foul smell

Is the gas related to certain food(s)? _____ If so, describe: _____

Do you have bowel problems? _____ Do you feeling your bowel movements are incomplete? _____

Describe complaints: _____

Have you seen a doctor about them? _____

Do you use a stool softener or laxative? _____ Herbal laxative? _____ Suppository? _____

Product name(s): _____

If yes, how often? _____ If yes, used for how long (days, months, years)? _____

Do you have hemorrhoids or other rectal problems (itching, fissures, etc.)? _____

If yes, describe: _____

If yes, have you been seen by a doctor? _____

Exercise: Describe your regular routine in the table below

Type of exercise	Frequency	Duration

Energy: On a scale from 1 to 10 where 1 = "*can't get out of bed*" and 10 = "*optimal energy*"

Please rate your normal energy level: _____ Any relation to food or drinks? _____

If yes, describe examples: _____

Diet: What type of diet best describes your general dietary habits? *(Circle the best response)*

junk food/fast food eater combination (from junk food to health conscious) vegetarian

vegan raw macrobiotic natural food eater (over 50% organic) health conscious

How many servings of fruit do you eat per day? _____

How many servings of vegetables do you eat per day? Raw _____ Cooked _____

How much dairy do you eat per day? _____ How much meat do you eat per day or week? _____

Dietary Goal: My diet goal is to be: *(Circle the best response)*

combination (from junk food to health conscious) vegan raw macrobiotic

natural food eater (over 50% organic) vegetarian health conscious

Water: How much water do you drink per day? _____ glasses or _____ ounces

Water Source: Tap *(from city or well)* Bottled Filtered Boiled Whatever is available

Describe your typical daily diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Smoking: Do you currently smoke? _____ If yes, how much? _____ How long? _____

Alcohol: Do you currently drink? _____ If yes, how much? _____ How long? _____

Stress: On a scale from 1 to 10 where 1 = "is mellow" and 10 = "stressed out"

Please rate your current stress level: _____ What are the main sources of your stress? _____

_____

_____

If your stress level 5 or more, what step(s) are you taking to reduce your stress? _____

_____

Do you notice changes in your bowel habits when you make any changes to exercise, diet, water intake, and stress? _____ If so, please explain: _____

For women pre-menopausal: Monthly cycle: Do you experience PMS? _____

Are your periods more than 6 days? _____ Are you susceptible to chronic yeast infections? _____

What do you hope to achieve from this colon hydro-therapy appointment? _____

Do you have any specific concerns? _____ If yes, explain: _____

My signature below indicates I have honestly answered all of the questions above and supplied any additional relevant information within this intake form.

_____ _____

Client Name (Signature) Date

_____

Client Name (Printed)

** ***Reminders*** **

*Please stop **eating** 2 hours prior to your appointment and stop **drinking** 1 hour prior to your appointment.*

Release Statement

I acknowledge that *High Stream Healing-Boise Colon Cleanse* and all staff members are not medical doctors. I understand that *High Stream Healing-Boise Colon Cleanse* and staff members of *High Stream Healing- Boise Colon Cleanse* may provide nutritional and other health related information to help me attain and maintain my best health. All suggestions are designed to help me move towards my best state of health through personalized recommendations in lifestyle, exercise, health habits, and advanced nutrition. I understand that *Juliana Benner,* as well as staff members of *High Stream Healing-Boise Colon Cleanse* do NOT diagnose, treat, or claim to cure any illness or disease.

I have been made aware of all contraindications for colon hydro-therapy and am here on this day and any subsequent visit by my choice and solely on my own behalf. I hereby release and discharge Juliana Benner and *High Stream Healing-Boise Colon Cleanse* from any and all claims which I or my agents ever had, now have or may have relating to or arising out of services provided or recommendations that I have received. I acknowledge that it is my responsibility to consult with my physician or other health care providers relating to any disease or condition that I may have.

I give permission to share my health information with other practitioners and health care professionals who are also providing services for my care.

I have read this informed consent and understand it. I am not a minor (under the age of 18).

I understand the above Financial & Cancellation Policy and will abide by these charges.

I am signing this release voluntarily.

Client Name (Signature)

Client Name (Printed)