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.*

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