Colon Hydrotherapy - Client Intake Form

Name: ______________________ Today's Date: ______________

Address: ______________________

City: ______________ Province: ______________ Postal Code: __________

Phone(Day): ________ Phone(Eve.): ________ E-mail Address: ______________

Age: ________ Occupation: ______________________

Have you had colonics before? ________ How many? ________ When? ________

Other Cleansing experiences include: ______________________

____

Name of your M.D., Herbalist and/or N.D. ? ______________________

What are your reasons for having colonics? ______________________

Diet and Lifestyle

On a scale of 1 to 10, what is your stress level? ______________ Your Blood Type: ________

Vegetarian? ________ For how many years? ________ Eggs and dairy? ________

Or vegan? ________ Raw foods % in diet? ________

Frequency of Consumption? Poultry/Fish: ________ Red Meat: ________ Dairy: ________

Eggs: ________ Flour Products/Bread: ________ Caffeine: ________ Sugar: ________

Salt: ________ Artificial Sweeteners: ________ Cola/Pop: ________ Drink alcohol? ________

Do you buy organically grown foods? ______________ Smoke? ________

Take Medical Drugs? (please list), *Gabapenting? YES/NO ______________

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____

Take Herbal and/or nutritional supplements? (please list) ______________

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Health Conditions

Any problems with: Constipation, Diarrhea, Abdominal pain, Hemorrhoids, Gas? (please circle.)

How often do you have a bowel movement? ______________________

Any other colon problems? now: ______________ or in the past: ______________

Have you taken antibiotics in the past? ________ Chemical laxatives? ________ Birth Control? ________

Food allergies or food restrictions: ______________________

Diagnosed health conditions: ______________ Hepatitis/HIV: ________ If yes, type: ________

Do you have, or are you a carrier, of an infectious disease? ________ If so what? ________

Bleeding disorder? ______________ Heart condition? ______________

Contraindications for Colon Hydrotherapy

Do you presently have, or have you had any of the following conditions? If in the past how long ago? Please circle yes or no:

Condition		Condition	
Cancer of the Colon or GI tract	YES/NO	Vascular aneurysm	YES/NO
Acute abdominal pain	YES/NO	Renal insufficiency	YES/NO
Recent history of GI bleeding	YES/NO	Epilepsy or psychoses	YES/NO
Congestive heart failure	YES/NO	Cirrhosis	YES/NO
Uncontrolled Hypertension	YES/NO	Carcinoma of the rectum	YES/NO
History of Seizures	YES/NO	Severe hemorrhoids past	YES/NO
Abdominal surgery	YES/NO	Severe hemorrhoids current	YES/NO
Intestinal perforation	YES/NO	Diverticulitis	YES/NO
Fissures or fistula	YES/NO	Recent heart attack	YES/NO
Abdominal hernia	YES/NO	General debilitation	YES/NO
Pregnancy current	YES/NO	Recent colon or rectal surgery?	YES/NO
Pregnancy past	YES/NO when?		

How did you hear about our office?:

*Doctors Referral: name ______________ *Health Care Practitioner: name ______________

*Phone Book: ________ *Magazine ________ *Friend: name ______________

*Card/Flyer: ________ *Internet ________ *Other: ______________

Notes: ______________________________