— INTAKE FORM

Colon Hydrotherapy
Client Intake Form.

PLEASE WRITE LEGIBLY. All information is for office use only.

Date _____ Date of Birth _____ Age _____ Gender _____

Name _____ Phone _____

Complete Address

Email (for newsletters and special offers)

Occupation

How did you hear about us?

Emergency contact information

Personal goals for these services

Military (past or present) or immediate family of military

Colon hydrotherapy clients — is this your first session? ___ yes ___ no. If no, when and where was the last?

General Health

Have you been hospitalized? When? Why?

Have you been diagnosed with a major illness? ___ yes ___ no When? What?

Explain any medical treatment you are currently receiving.

List the medications you take, and for what.

List the supplements you take, and for what.

List any programs you follow (fasting, weight loss, nutrition, etc.).

List all your allergies.

Are you currently pregnant? ___ yes ___ no

How many pregnancies? _____ Full-term _____ Miscarriage _____ Induced _____

Did you gain additional weight with each pregnancy? ___ yes ___ no

Did you lose the pregnancy weight after each child? ___ yes ___ no

How often do you have a bowel movement? _____ Constipation? ___ yes ___ no

Do you have surgical metal pieces in your body? ___ yes ___ no

Conditions Checklist

Do you currently have, or have you had in the past, any of the following? Write **C** for Current or **P** for Past next to each that applies.

___ Abdominal gas/pain
___ Abdominal hernia
___ Acid reflux
___ AIDS/HIV
___ Anal bleeding
___ Anal discomfort/itching
___ Anxiety
___ Anemia
___ Aneurysm
___ Anorexia
___ Appendicitis
___ Arthritis
___ Asthma
___ Atonic colon
___ Autoimmune disorder
___ Bad breath
___ Belching
___ Bloating (general)
___ Bloating after eating
___ High/low blood pressure
___ High/low blood sugar
___ Bulimia
___ Cancer (type: _____)
___ Candida
___ Celiac disease
___ High/low cholesterol
___ Chronic fatigue
___ Chronic pain
___ Cirrhosis
___ Colitis
___ Congestive heart failure
___ Contagious disease
___ Constipation
___ Cramps
___ Crohn's disease
___ Depression
___ Diabetes
___ Dialysis
___ Diarrhea
___ Diverticulosis
___ Diverticulitis
___ Dizziness
___ Eczema
___ Edema
___ Environmental allergies
___ Epilepsy
___ Epstein-Barr virus
___ Extreme weight gain/loss
___ Fainting
___ Fatigue after eating
___ Fever/chills
___ Fibromyalgia
___ Fibroid cysts
___ Fissure/fistula
___ Gallstones
___ Headaches/migraines
___ Heart condition
___ Hemorrhoids
___ IBS (irritable bowel)
___ Indigestion
___ Intestinal perforation
___ Irregular period
___ Kidney disorder
___ Kidney stones
___ Liver disorder
___ Loss of sleep
___ Low libido
___ Lung disorder
___ Lupus
___ Lyme disease
___ Metal toxicity
___ Menopause
___ Mental disorder
___ Nausea
___ Osteopenia
___ Osteoporosis
___ Pacemaker
___ Parasites
___ PMS
___ Polyp
___ Prolapsed colon

___ Prostate disorder
___ Recent surgery
___ Rectal bleeding
___ Renal failure
___ Seizures
___ Sinus condition
___ Skin condition
___ Spastic colon
___ Sweating
___ Thyroid disorder
___ Ulcer
___ Urinary tract infection
___ Vomiting
___ Other: _____

Nutrition

Are you: ___ vegan ___ vegetarian ___ omnivore (eats animal protein)

Do you want to change? To which group? Why?

Usual breakfast

Usual lunch

Usual dinner

Usual snack

Cravings you have regularly

Do you have a sensitivity to any of the following?

___ lactose ___ casein ___ wheat ___ gluten ___ nightshades ___ additives ___ coloring ___ MSG ___ preservatives ___ latex

___ fish ___ pork ___ beef ___ chicken ___ turkey ___ peppers ___ eggplant ___ potatoes ___ tomatoes

Have you experienced any significant physical and/or emotional trauma? ___ yes ___ no If yes, explain:

If you have an exercise routine, explain it.

Indicate your consumption as follows: **F** — Frequent (5–7×/week), **M** — Moderate (2–4×/week), **L** — Light (1× or less/week), **N** — Never

___ fresh fruit	___ fresh vegetable juice	___ fresh fruit juice
___ smoothies	___ nuts/seeds	___ beans/legumes
___ eggs	___ salad	___ raw vegetables
___ water	___ salt	___ organic foods
___ sweets	___ cooked vegetables	___ caffeine (coffee/tea)
___ soda	___ alcohol	___ processed foods
___ flour products	___ fast food	___ sugar

___ tobacco

___ antacids

Other

How much water do you drink per day? Source?

Do you drive a hybrid vehicle? ___ yes ___ no

Do you live near radio towers, high-voltage power lines, substations, etc.? ___ yes ___ no

What electrical devices are in your bedroom?

Where is your cell phone while you sleep?

Have you ever had Lyme disease? ___ yes ___ no Treatment?

Have you been exposed to mold? ___ yes ___ no Explain:

Do you have amalgam (silver) fillings? ___ yes ___ no How many?

Do you have root canals? ___ yes ___ no How many?

How many wisdom teeth have been extracted?

Do you have any kind of implants? (breast, cheek, etc.)

All the information provided above is true and complete. I do not expect a diagnosis, prescription, or cure, and I understand that the service/consultation is **NOT** a substitute for a medical examination, treatment, or diagnosis.

I understand that 48-hour cancellation notice is required for all appointment changes and cancellations, the sole exception being my own medical emergency or that of an immediate family member. I agree to pay the **$60** no-show fee for missed appointments without the required notice.

Signature _____ **Date** _____