



Colonic Intake Form

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone/ Work: _____ Home: _____ Cell: _____

Email: _____ Occupation: _____

Date of Birth: _____ Name of Physician: _____

Have you had a colonic here? () yes () no if yes, when? _____

Is a family member a client here? () yes () no If yes, Name: _____

How did you hear about us? () Doctor () family member () friend () Ad () Other _____

In case of emergency, who would you like us to notify?

Name/Relation: _____ Phone number: _____ Cell: _____

Major physical complaints _____

Any surgeries? () yes () no _____ If yes, date of last surgery: _____

Medications and Supplements you take (please list): _____

Allergies (medication, food, environmental, etc.): _____

What do you want to accomplish by coming here? _____

Elimination Assessment

How many meals a day do you eat? _____ Which ones? _____ () breakfast () lunch () dinner

Bowel movement _____ x per day _____ x per week _____ x per month

Do you use a stool softener, laxative or herbal laxative? () yes () no Name of product : _____

If yes, how often _____ x per day _____ x per week _____ x per month

My stools are:

Consistency

() soft, well formed	() large and hard	() large 2" wide x 6" length
() difficult to pass	() medium 1" x 4"	() loose, not watery
() thin, long narrow	() diarrhea	() often float
() alternates between constipation and diarrhea	() small and hard	

Elimination Assessment (continued)

Odor

- () offensive usually () occasionally () little odor

Color

- () medium brown () yellow brown () dark brown
() dark or black () greasy and shiny () greenish
() blood visible () mucous () varies continued on next page

Do you have trouble initiating a bowel movement? () yes () no

Is your stool too big or hard? () yes () no

Do you have abdominal discomfort or cramping accompanying bowel movements? () yes () no

If yes, how often? _____

Do you suffer from intestinal gas () yes () no

If yes, describe? () daily () occasionally () painful () excessive () foul () no odor

Do you have or have you ever had one or more of the following? (Check all that apply)

- () history of gall stones () hair loss () dry mouth and eyes
() poor sleep habits () muscle cramps () swollen eyelids
() moods of depression () swollen ankles () joint stiffness
() poor memory () nose bleeds () fevers
() reduced appetite () itching anus () period of vomiting
() colds – often () AIDS/HIV+ () hepatitis
() fibromyalgia () herpes 1,2,6,7 () multiple sclerosis
() Parkinson’s disease () epilepsy () meningitis (bacterial or viral)
() blood transfusion () chronic fatigue () herpes simplex II (genital herpes)
() pain between the shoulder blades () inflamed appendix
() Other _____

Do you:

- () eat when nervous?
() gain or lose weight easily?
() get jittery when a meal is delayed?
() worry?
() feel insecure?
() have dental fillings?
() have a root canal?
() have silicone/saline breast implants? How long? _____

Are you:

- () disinterested in food
() bloating/Gas
() burping
() food Regurgitates
() feeling fullness after meals
() nausea after eating
() having painful and burning sensations after meals

Health History (please check all that apply)

General

- headaches
- insomnia
- loss of weight
- dizziness
- fainting spells
- history of seizures
- fatigue
- enlarged thyroid
- double/blurred vision
- depression
- cancer
- cirrhosis

Gastrointestinal

- colitis
- constipation
- Crohn's disease
- ulcerative colitis
- diverticulitis
- diverticulosis
- gall bladder disease
- fissures/fistula
- inflamed appendix
- family history of colon cancer
- rectal bleeding
- hemorrhoids

Respiratory

- shortness of breath
- chronic cough
- vomiting blood
- emphysema
- bronchitis
- asthma (wheezing)
- other _____

Cardiovascular

- high blood pressure
- hardening of arteries
- angina (chest pain)
- poor circulation
- rapid heart beat
- irregular heart beat
- congestive heart failure
- liver trouble
- swelling of ankles

Muscle and Joint

- arthritis
- bursitis
- low back pain
- neck pain
- swollen joints
- other _____

Urinary

- kidney infection or stone
- painful urination
- prostate trouble
- kidney failure
- other _____

Skin

- bruise easily
- dryness
- itching
- rash
- varicose veins
- other _____

Women

- painful menstruation
- last menstrual period -
date _____
- other _____

Signature: _____ **Date:** _____

Indications and Contraindications

Last Name: _____ First Name: _____
Address: _____ Apt/Suite: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____

Indications for Colon Hydrotherapy

INTENDED USE STATEMENT:
"THE INDICATION FOR USE OF THIS DEVICE MUST BE RESTRICTED TO COLON
CLEANSING WHEN MEDICALLY INDICATED, SUCH AS BEFORE RADIOLOGICAL OR
ENDOSCOPIC EXAMINATION."
21CFR876.5220

Contraindications for Colon Hydrotherapy

Contraindications: a sign or symptom suggesting that a certain line of treatment should be discontinued for avoided.

Please circle if you have any of the following:

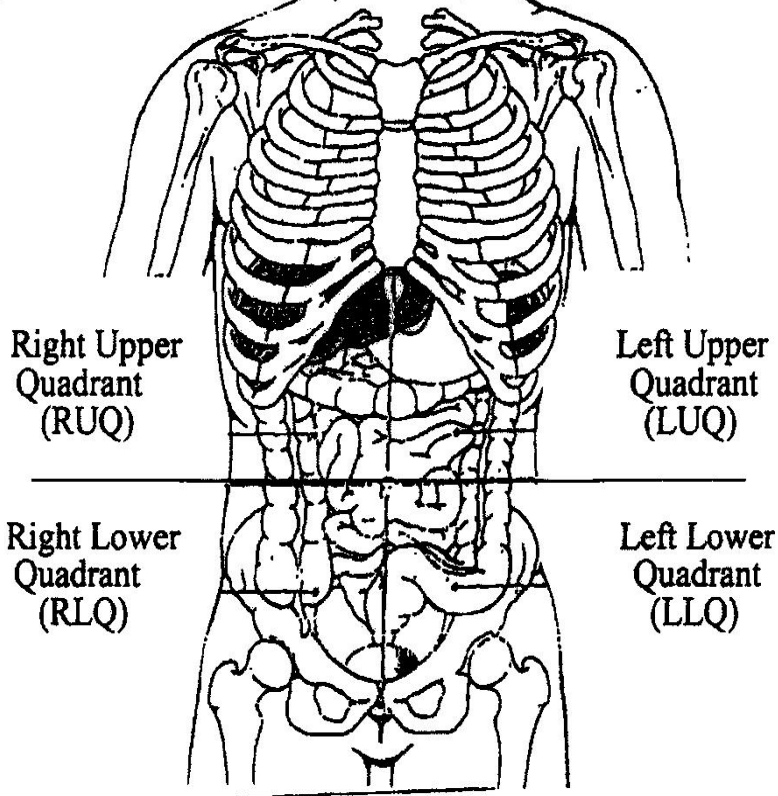
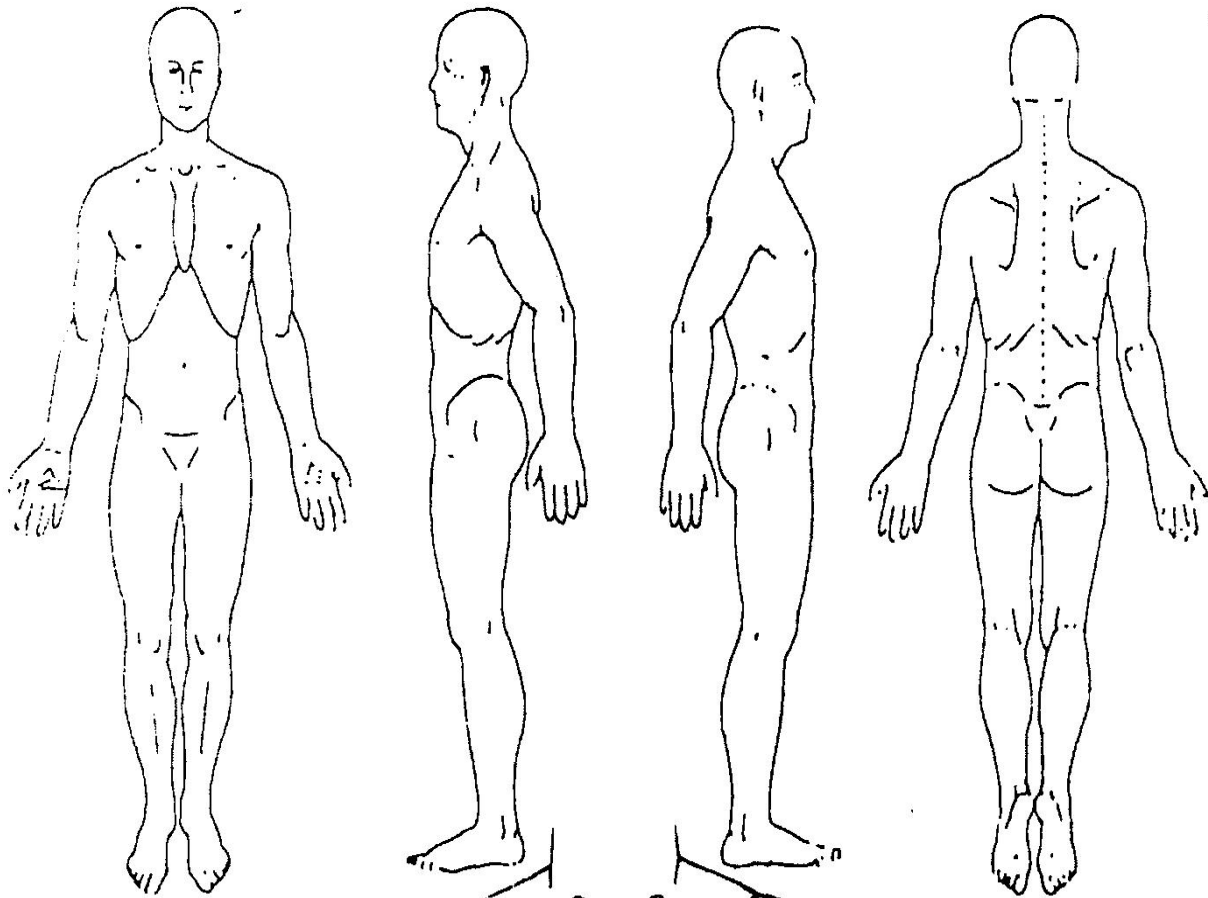
- Severe cardiac disease (uncontrolled hypertension or congestive heart failure)
- Aneurysm • Intestinal Perforations
- GI hemorrhoids • Abdominal Surgery
- Severe hemorrhoids • Carcinoma of the Colon or Rectum
- Fissures/fistulas • GI Hemorrhage/Perforation
- Abdominal hernia • Diverticulitis
- Recent colon or rectal surgery • Crohn's Disease
- Renal insufficiency • Pregnancy/Advanced pregnancy
- Inflamed Appendix

I have read and understand the information on this form:

Dated: _____ of 20_____

Signature: _____

INDICATE THE AREAS IN WHICH YOU ARE PRESENTLY EXPERIENCING PROBLEMS



CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPTIONS

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professional who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professional.

I understand and have been provided with a *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will post the new notice in the waiting area and in each examination room. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out my treatment, payment, or health care operation and that I may revoke this consent in writing, except to the extent that the organization has already taken Action I the reliance hereon.

Cancellation Policy

As a courtesy to other clients and therapists, **appointments must be cancelled 24 hours in advance.** You are charged in full for all scheduled appointments, unless the office is able to reschedule your time.

No-shows will be charged in full.

What if I arrive late? Arriving to your appointment late will simply limit the time for your session. Your session will end on time so that the next client will not be delayed. If you arrive late it is up to you whether you prefer to receive a shortened session or pay for the appointment and reschedule.

I agree to and understand the above policy.

Your Signature _____ Date _____

