CLIENT INTAKE FORM

NAME____

MALE/FEMALE________________ DATE________________

ADDRESS____

____

PHONE__________________________ ALT. PHONE__________________________

EMAIL____

OCCUPATION______________________________ BIRTH DATE__________________________

HOW DID YOU HEAR ABOUT US?____

HAVE YOU RECEIVED COLONICS BEFORE?___________ DATE________________________

RESULTS____

ARE YOU UNDER A DOCTOR'S CARE?___________ IF SO, PLEASE EXPLAIN____________________________

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DOCTOR'S NAME___________________________DOCTOR'S PHONE___________________________

HAVE YOU HAD A BARIUM X-RAY?_____________ COLONOSCOPY?_____________ DATE_______________

REASON AND RESULTS____

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HOW MANY BOWEL MOVEMENTS PER DAY DO YOU HAVE?________WHAT IS YOUR FLUID INTAKE PER DAY __________

PLEASE CIRCLE ANY OF THE FOLLOWING HEALTH CONDITIONS THAT APPLY TO YOU: HEMORRHOIDS SEVERE HYPERTENSION PREGNANCY ANEURYSM SEVERE ANEMIA ABDOMINAL HERNIA COLON CANCER GI HEMORRHAGE/PERFORATION RENAL INSUFFICIENCY, FISSURES/FISTULAS RECENT COLON SURGERY CIRRHOSIS OF THE LIVER CROHN'S DISEASE CARDIAC CONDITION CARCINOMA COLITIS DIVERTICULOSIS LUPUS ABDOMINAL SURGERY DIALYSIS PATIENT

ANY OTHER MEDICAL CONDITION THAT WE SHOULD KNOW ABOUT____

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I HAVE NOT BEEN DIAGNOSED WITH ANY CONTRAINDICATIONS FOR COLON IRRIGATION. (SEE ABOVE*). I AM AWARE THAT COLON HYDROTHERAPISTS ARE NOT PHYSICIANS AND THEREFORE DO NOT DIAGNOSE OR PRESCRIBE. IF DURING THE SESSION I EXPERIENCE DISCOMFORT OR PAIN, I AM RESPONSIBLE FOR IMMEDIATELY STOPPING MY SESSION AND NOTIFYING THE THERAPIST! THIS FACILITY DOES NOT CLAIM TO CURE, DIAGNOSE OR TREAT ANY CONDITION OR DISEASE.

NAME____DATE______________