CLEANSE
COLON HYDROTHERAPY

Intake Form

Before your first visit please fill out the intake form.

Name* _____

Address* _____

City* _____ State* _____ Zip* _____

May we contact you at this address? Circle One Y N

Email* _____ Birthdate* _____

Height* _____ Weight* _____

Best phone number to reach you* _____

Emergency Contact phone number* _____

How did you learn about Cleanse Colon Hydrotherapy? _____

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)? Circle One Y N

If yes, describe _____

Is colon hydrotherapy part of a protocol that a doctor or other healthcare professional has referred or prescribed for you? Circle One Y N

If yes, when? _____ Doctor's Name* _____

Type of Doctor: Circle One PCP Gastrointestinal Doctor Proctologist Other

Allergies: List all known _____

Health concerns: List top _____

Do you know if you have parasites? Circle One Y N

If yes, describe _____

Have you had any abdominal area surgeries? Circle One Y N

If yes, when? _____

Circle any surgeries that apply

C-Section Gallbladder Gastric Bypass Hysterectomy Lap Band Vaginal Mesh Other

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If yes to any of the above, do you feel that you have had a change in bowel habits? Circle One Y N

Back Issues

Do you have any problems/pain in the lower back (lumbar region? Circle One Y N

If yes, describe _____

Colonic History

Have you ever had a colonic before? Circle One Y N

If yes, when and please describe your experience

_____

Type of device used (Colonic system). Circle all that apply

Closed System Open System Gravity Not sure

Digestion

How is your digestion? Circle all that apply

Adequate Poor Acid reflux Bloating Burning/pain in stomach Indigestion Ulcers Other

If other complaints, please describe _____

Have you seen a doctor about them? Circle One Y N

Bowel Habits

How often do you have bowel movements? Circle One 3 per day 2 per day 1 per day skips days

How are your bowel eliminations normally? Circle One Requires straining Effortless Varies

If varies, please describe _____

Amount? Circle One normal too little too large

Consistency? Circle One normal too hard very soft diarrhea

Color? Circle One brown black whitish greenish

Other? Circle One lots of mucus foul smell

Do experience gas, and is it related to certain food(s)? Circle One Y N

If yes, describe _____

Do you feel your bowel movements are incomplete? Circle One Y N

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Do you have bowel problems? Circle One Y N

If yes, describe _____

Have you seen a doctor about them? Circle One Y N

Do you use a stool softener or laxative? Circle One Y N

If yes Circle One Herbal laxative Suppository

Product name(s) _____

If yes, used for how long? Circle One days months years

Do you have hemorrhoids or other rectal problems (itching, fissures, etc.) ? Circle One Y N

If yes, describe _____

If yes, have you been seen by a doctor? _____

Exercise

Type of exercise (please include frequency and duration)

_____

Diet

What type of diet best describes your general dietary habits? Circle all that apply

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? _____

Are the vegetables? Circle One raw cooked combination

Do you eat dairy? Circle One Y N If yes, how often? _____

Do you eat meat? Circle One Y N If yes, how often? _____

Describe your typical daily diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Water

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How much water do you drink per day? _____

Water Source: Circle all that apply

Tap (from city or well) Bottled Filtered Boiled Whatever is available

Alcohol

Do you currently drink? Circle One Y N

If yes, how much and how often? _____

Stress

Please rate your current stress level: on a scale from 1 to 10

where 1 = “is mellow” and 10 = “stressed out”

What are the main sources of your stress? _____

If your stress level is 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 or stress? Circle One Y N

If yes, please explain: _____

What do you hope to achieve from this colon hydrotherapy appointment?

_____

Do you have any specific concerns?

_____

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Contraindications Questionnaire To Determine Your Eligibility for Colon Hydrotherapy Session

These standards are meant as general guidelines. Because each person has a unique medical history, you should consult your physician to determine if you are healthy enough to undergo colon hydrotherapy. Persons with certain medical conditions (contraindicated conditions) are prohibited from undergoing colon hydrotherapy.

These conditions include the following:
Contraindicated conditions (Not eligible for Colonic)

- Kidney Dialysis
- Pregnancy
- Aneurysm
- Congestive Heart Failure (e.g. Organic Valve Disease)

Persons with certain medical conditions (contraindicated conditions) need approval from and/or by prescription from their physician.

Conditions by prescription only

- Anemia: Contraindicated if a patient is already at risk of cardiac compromise due to Anemia. They may experience worsening of their Anemia due to secondary fluid absorption through the large intestine.
- Carcinoma: Contraindicated when Carcinoma is located in the rectum or large intestine.
- Crohn's Disease: Contraindicated when advanced.
- Ulcerative Colitis: (Severe) Contraindicated only when active or bleeding.
- Diverticulitis: (Severe or Acute) Due to (current infection) the inflamed colonic mucosa of the intestinal wall has a heightened chance of perforation due to water pressure thus creating a contraindication.
- Epilepsy/Seizures: Contraindicated when uncontrolled.
- Fissures/Fistulas: Contraindicated if painful and bleeding.
- GI Hemorrhage/Perforation: Contraindicated if intestinal perforation.
- Hemorrhoids: Contraindicated when excessive bleeding is present.
- Hernia: (Incarcerated Abdominal) Contraindicated if painful.
- Prostatitis: Contraindicated when acute
- Surgery: (Recent Abdominal) Contraindicated within 6-months post-surgery: Colon, Rectum, or other abdominal surgery.
- Tumors: Contraindicated when it is located in the Rectum or the Colon.

My signature below indicates I have honestly answered all of the questions above and supplied any additional relevant information within this intake form. I have read the above and do not have any of the contraindicated conditions.

_____ Date * _____

** Reminders **
Please stop eating 2 hours prior to your appointment and stop drinking 1 hour prior to your appointment.