CLIENT INFORMATION & MEDICAL HISTORY
COLON HYDROTHERAPY

PERSONAL HISTORY

Client Name:_____ Today's Date:_____

Home Address:_____ City:_____ ___State_____ Zip_____

Home Phone(_____)_____ Work Phone (____)_____ Mobile (____)_____

Date of Birth:_____ Age: _____ Occupation:_____

Height _____ Weight_____ Female_____ Male_____ Marital Status _____**Blood Type** _____

Emergency Contact Name and Phone_____

Email: _____ **Facebook:**_____ **Instagram:** _____

Who can we thank for referring you to us? Internet _____ Phone Book _____ Name of Referral _____

24 Hour Cancellation Policy: **I**f you must cancel your appointment, please call at least 24 hours in advance or a $30.00 charge will be added to your bill. If there is no answer when you call, you can leave a message and we will acknowledge that you have cancelled your appointment so that we may reschedule. Please initial _____

Colon Therapy Procedure: I have been informed and agree to self-insertion and self-retraction of the speculum.
Please Initial _____

Colon Therapy Senate Bill 577: I have read and understand that the services provided at this center are in compliance with section 2053.6 of the business and Profession Code of the State of California.
Please initial _____

MEDICAL HISTORY

Are you currently under the care of a physician? _ Yes _ No If yes, for what? _____
_____

Do you have a prescription for this visit? _____ If yes, do we have a copy on file? _____If yes, Date_____

Is Colon Hydrotherapy part of a protocol that a healthcare professional has referred or prescribed for you? _ Yes _ No

Have you had Colon Hydrotherapy before ____ yes _____no. If yes when was the last time _____

If yes, Doctors and Type of Doctor_____
Reason _____Date of referral/prescription_____

Do you have any of the following medical conditions? Please check all that apply:

_____Abdominal Hernia	**_____Abdominal Surgery**	**_____Abnormal Distension**	**_____Acute Liver Failure**
_____Anemia	**_____Aneurysm-All Types**	**_____Cancer of the Colon**	**_____Cardiac Condition**
_____Crohns Disease	**_____Colitis**	**_____Dialysis Patient**	**_____Diverticulitis**
_____Fissures & Fistulas	**_____Hemorrhaging**	**_____Hemorrhoidectomy**	**_____Intestinal Perforations**
_____Lupus	**_____Pregnant**	**_____Rectal/Colon Surgery**	_____Renal Insufficiencies
_____Irritable Bowel Syndrome	_____AIDS	_____Diverticulosis	_____Bladder Infections
_____Bloating	_____Blood in Stool	_____BM Difficult	_____Itching Anus
_____Constipation	_____Diarrhea	_____Infectious Disease	_____Hemorrhoids
_____Colonoscopy	_____Rectal Bleeding	_____Hepatitis B or C	_____Parasites

Do you have any communicable Disease? _ Yes _ No If yes, explain:_____

Do you have any other health problems or medical conditions: Please list:_____
_____

MEDICATIONS & SUPPLEMENTS

List all you now take regularly including over the counter:_____
_____

Do you take digestive aids/laxatives? _ Yes _No If yes, describe:_____

Are you on any steroids? _ Yes _ No Injections/oral _____

Are you on any blood thinners? _ Yes _ No Are you on any diuretics? _Yes _No

What was the most recent time you took antibiotics?_____ Why?_____

ADDITIONAL INFORMATION:

Describe your regular routine for exercise: _____
_____

On a scale of 1 to 10 where 1 = can't get out of bed and 10=optimal energy, describe your normal energy level:_____

How many servings of vegetables do you eat per day?_____ How many servings of fruit per day?_____

How much water do you drink per day? _____

How much dairy do you eat per day?_____ How much meat do you eat per day or week?_____

Do you smoke? _ Yes _ No If yes, how much and how long?_____

Do you drink alcohol? _ Yes _ No If yes, how much and how long?_____

How often do you have a bowel movement? _____skips days _____1 per day _____2 per day _____3 per day

Color and consistency of bowel movement_____

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

Do you have specific concerns? _ Yes _ No If yes, explain:_____

If you are a Federal, State or Local Agent, upon entering these premises you must declare same or under the Bivens Act, Article 42, be held personally and individually.

My signature below indicates that I have honestly answered all of the questions above and supplied any additional relevant information within this intake form.

_____Date:_____
Client Name (Printed clearly)

_____
Client Signature

Revised 11-24-16/cece