

Client Information / Pre-Treatment Interview

Name: _____ Today's Date: __ _____
Address: _____
City: _____ Prov. _____ Postal _____
Phone (Day): _____ Phone (Eve.): _____ E-Mail Address: _____
Date of birth: _____ Occupation: _____
Have you had colonics before? _____ How Many? _____ When? _____
Other Cleansing experiences include: _____
Name of your physician: (ND, MD or other) _____
What are your reasons for having colonics? _____

DIET AND LIFESTYLE

On a scale of 1(low) to 10(high), what is your stress level? _____ Your Blood Type: _____
Vegetarian? __ for how many years? _____ eggs and dairy? __ or vegan? __ Raw foods % in Diet? _____
Frequency of Consumption? Poultry/Fish: _____ Red Meat _____ Dairy: _____
Eggs: _____ Flour Products/Bread: _____ Caffeine: _____ Sugar: _____
Salt _____ Artificial Sweeteners: _____ Soft Drinks: _____ Drink alcohol? _____
Do you buy organically grown foods? _____ Do you smoke? _____
Please list prescription meds: _____
Please list herbal and/or nutritional supplements? _____

HEALTH CONDITIONS

Any problems with: Constipation, Diarrhea, Abdominal pain, Hemorrhoids, Gas? Other _____ (please circle.)
How often do you have a bowel movement? _____
Any other colon problems? now: _____ or in the past: _____
Have you taken antibiotics? Now _____ in the past? _____ Chemically laxatives? _____ Birth Control? _____
List food allergies or food restrictions: _____
Diagnosed health conditions: _____ Hepatitis-HIV: __ ____ If yes type: _____
Do you have, or are a carrier, of an infectious disease? _____ If so what? _____
Bleeding disorder? _____ Heart condition? _____

Contra indications for Colon Hydrotherapy: Do you presently have, or have you had any of the following conditions? If in the past how long ago?

Please circle yes or no:

Cancer of the Colon or GI tract	YES / NO	Vascular aneurysm	YES/NO
Acute abdominal pain	YES / NO	Renal insufficiency	YES/NO
Recent history of GI bleeding	YES / NO	Epilepsy or psychoses	YES/NO
Congestive heart failure	YES / NO	Cirrhosis	YES/NO
Uncontrolled hypertension	YES/ NO	Carcinoma of the rectum	YES/NO
History of Seizures	YES / NO	Severe hemorrhoids	YES/NO
Abdominal surgery	YES / NO	Intestinal perforation	YES/NO
Diverticulitis	YES / NO	Fissures or fistula	YES/NO
Recent heart attack	YES / NO	Abdominal hernia	YES/NO
General debilitation	YES / NO	Pregnancy	YES/NO
Recent colon or rectal surgery?	YES / NO		

How did you hear about our office?

All information will be held in strict confidence. This information may help your health care provider to assist you better in your quest for optimal colon hydrotherapy results. It is not intended to diagnose or prescribe and is not a replacement for your regular medical attention by your Physician. I have read the contra indications for colonic irrigation listed above and with my signature below I testify that I DO NOT HAVE ANY of the listed conditions. Please print your name: _____

Signature: _____ Date: _____
Address: _____ Telephone: _____

I agree to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements, missed appointment fees as well as other applicable fees. .

Date: _____ Patient Signature _____

We require 24 hour notice for cancellation or rescheduling