Colon Hydro Therapy Intake

Date _______________

Name _________________________________ DOB ___________ Gender: Male Female Ht _______ Wt _______

Address ___________________________________ City __________________ State ______ Zip _______________

Home Phone ___________________Cell Phone __________________Email _____________________ Occupation _______________

Emergency contact ____________________________ Relationship ____________ Phone _________________________

Have you had colon hydrotherapy before? Yes No If Yes, when? _____________ With whom? _______________________

Referred by _______________________ I am under the care of Dr.______________________ No current health care provider.

Please check one: I am self treating. Report my tx progress to Dr. ____

Did you have a BM today? Yes No Typical BM frequency, consistency is ____

Do you use laxatives? Yes No If yes, what and how often ____

Do you use enemas? Yes No If yes, what and how often ____

Do you exercise? Yes No If yes, what and how often ____

Do you follow a particular diet? ____

Known Allergies ____

Please list all medications, OTC drugs and supplements you take **regularly**:

____

____

What are your treatment objectives? ____

Eating Habits

How much water do you consume daily? ______________________________ Coffee or Caffeinated drinks? ____________________

Meals per day _______________ Do you eat Breakfast? Yes No Snacks ____________________________________

Food Cravings _______________________________ Food preferences ____

Food allergies ____

Please indicate the typical number of servings of each of these foods consumed in the average day:

Pasta	_______	Raw greens	_______	Water	_______
Bread	_______	Orange/Yellow veggies	_______	Juices/Smoothies	_______
Whole grains	_______	Potatoes	_______	Carbonated beverages	_______
Cheese	_______	Fruit	_______	Coffee / Tea	_______
Milk	_______	Red meat	_______	Alcohol	_______
Other Dairy	_______	Chicken	_______	Chocolate	_______
Tomatoes	_______	Fish	_______	Sugar	_______
Cooked greens	_______	Fats / oils	_______	Processed foods	_______

Please complete other side

Health History

Please indicate if have ever had or still have any of the following conditions:

Condition	Current	Past
Constipation	☐	☐
Diarrhea	☐	☐
Abdominal Gas/Bloating	☐	☐
Hemorrhoids	☐	☐
Fistulas or Fissures	☐	☐
Indigestion	☐	☐
Parasitic infections	☐	☐
'Spastic" or 'Lazy' colon	☐	☐
Diverticulitis	☐	☐
Bowel perforation	☐	☐
Infectious/Ischemic Colitis	☐	☐
Ulcerative colitis or Crohn's	☐	☐
GI bleeding	☐	☐
Colon cancer	☐	☐
Colon or rectal surgery	☐	☐
Abdominal surgery	☐	☐
Hepatitis	☐	☐
Liver cirrhosis	☐	☐
HIV / AIDS	☐	☐
Rectal incontinence	☐	☐
Muscle/joint pain	☐	☐
Skin problems	☐	☐
Headaches	☐	☐
Anemia or Blood Thinners	☐	☐
Asthma	☐	☐
Limiting fatigue	☐	☐
Bladder infections	☐	☐
Bladder incontinence	☐	☐
Kidney disease/failure	☐	☐
Prostatitis	☐	☐
Uterine prolapse	☐	☐
Stroke	☐	☐
Heart attack	☐	☐
Heart failure	☐	☐
Hypertension	☐	☐
Aneurysm	☐	☐
Abdominal hernia	☐	☐
Other cancers	☐	☐
Pregnancy	☐	☐

Toxicity Score

Please use the following scale to rate your current experience with the symptoms listed below.

0 = absent 1 = Mild 2 = Moderate 3 = Severe

Symptom	Score
Overweight or Underweight	
Protruding or distended abdomen	
Heartburn, indigestion	
Gas, burping, flatulence	
Bad breath	
Coated tongue	
Offensive body odor	
Skin blemishes or sallow complexion	
Dark circles under the eyes	
Dry or brittle hair or nails	
Compact, liquid, foul smelling stools	
Low back pain	
Premenstrual syndrome	
Sore joints	
Reduced sexual desire	
Headaches	
Fatigue	
Depression	
Irritability or anxiety	
Lack of energy	
Total Toxicity Score	

Consent To Treatment

I understand that colon hydrotherapy is a treatment using an FDA approved device. It is an adjunctive treatment to help my digestive health and aid in detoxification. I also understand that my therapist is not attempting to diagnose medical conditions or prescribe medical treatments. However, they may offer nutritional information and suggestions regarding my colon therapy and digestive health to help facilitate the treatment plan coordinated by my doctor. I also have the right to pursue this treatment and use any health information without a doctors supervision or consent. I acknowledge that no guarantee has been given or implied with regard to outcome. I understand the possible risks and alternatives to this treatment and willing consent to this and any future treatments with this therapist.

____________________________________ ____________________

Signature date