Intake Form: Colon Hydrotherapy

Today's Date: _____

Last Name: _____ First Name: _____ Telephone: _____

Email: _____ DOB: _____ Referred by: _____

What is the intention of your visit? _____

Please list any medications, supplements, or herbs you are currently taking. _____

_____

YES	NO	
☐	☐	Are you under a doctor's care? If so, please explain. _____
☐	☐	Do you have a bowel movement each day? How often? _____
☐	☐	Do you have to strain to have a bowel movement?
☐	☐	Do you use a stool softener, laxative, herbal laxative, or suppository (please circle)?
☐	☐	Do you have hemorrhoids, rectal problems, or rectal bleeding (please circle)?
☐	☐	Have you ever had a barium enema? If so, when? _____
☐	☐	Have you had any recent surgeries? If so, please explain. _____
☐	☐	Are you currently taking the following medications: Coumadin, Heparin, Plavix (blood thinners)?

What did you eat in the last 48 hours? _____

What do you typically eat? _____

How much water do you drink each day? _____

Colon Hydrotherapy Procedure: I have been informed and agree to self-insertion and self-retraction of the speculum. x _____

Colon Hydrotherapy 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. x _____ (please initial)

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 liable.

Do you have now or have you ever had the following:

CONTRAINDICATIONS FOR CURRENT CONDITIONS

No	Yes	Year	
___	___	____	ANAL FISSURE (acute, painful crack or tear)
___	___	____	ANAL FISTULA (infected anal fissure)
___	___	____	ANEURYSM, ABDOMINAL
___	___	____	BOWEL IMPACTION/ OBSTRUCTION
___	___	____	CROHN'S DISEASE
___	___	____	COLON CANCER
___	___	____	COLON, RECTAL, OR ABDOMINAL SURGERY (Less than 6 mo. ago) Kind of surgery? _____
___	___	____	COLOSTOMY
___	___	____	DIVERTICULITIS (Episode less than 6 mo. ago. You must be symptom-free at present to have a colonic.)
___	___	____	DYSENTERY
___	___	____	GASTROENTERITIS (food poisoning)
___	___	____	HEMORRHOIDS (Now painful or bleeding)
___	___	____	HERNIA, UNREPAIRED (Abdominal/Inguinal)
___	___	____	KIDNEY DIALYSIS
___	___	____	PREGNANCY (Current, and until 6 weeks post partum)
___	___	____	RECTAL BLEEDING (Current)
___	___	____	ULCERATIVE COLITIS

WE WILL NEED A PHYSICIAN'S REFERRAL TO PROCEED WITH YOUR COLONIC IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING CONDITIONS OR TREATMENTS:

No	Yes	Year	
___	___	___	ANTI-COAGULANTS
___	___	___	COLITIS
___	___	___	SEVERE DEBILITATION OR TERMINAL ILLNESS

DIAGNOSTIC PROCEDURE HISTORY

No	Yes	Year		Findings
___	___	____	SIGMOIDOSCOPY	_____
___	___	____	BARIUM ENEMA	_____
___	___	____	COLONOSCOPY	_____ (diverticulosis? polyps?)

OTHER HEALTH CONCERNS

No	Yes	Year	
___	___	_____	ADHESIONS
___	___	_____	ALLERGIES (if Glyco-thymoline® requested, check ingredients.)
___	___	_____	ANOREXIA
___	___	_____	BLOOD PRESSURE_____High _____Low
___	___	_____	BULIMIA
___	___	_____	CANCER Type_____ Treatment_____
___	___	_____	CANDIDA
___	___	_____	CHRONIC FATIGUE SYNDROME
___	___	_____	CONSTIPATION
___	___	_____	CYSTOCELE
___	___	_____	DIABETES _____insulin _____oral medications
___	___	_____	DIARRHEA For how long? _____
___	___	_____	EDEMA/SWELLING Where? _____
___	___	_____	FIBROMYALGIA
___	___	_____	GAS/BLOATING
___	___	_____	HEADACHES
___	___	_____	HEART PROBLEMS Type?_____

No	Yes	Year	
___	___	_____	HEMORRHOIDS (Not now acute)
___	___	_____	HEPATITIS circle one A B C D
___	___	_____	HIATAL HERNIA
___	___	_____	HIV
___	___	_____	HYPOGLYCEMIA (low blood sugar)
___	___	_____	IRRITABLE BOWEL SYNDROME
___	___	_____	INJURIES, RECENT explain_____
___	___	_____	KIDNEY PROBLEMS
___	___	_____	LATEX ALLERGY
___	___	_____	LEAKY GUT SYNDROME
___	___	_____	OSTEOPOROSIS
___	___	_____	PARASITES
___	___	_____	POLYPS
___	___	_____	RECTOCELE
___	___	_____	SKIN PROBLEMS Explain_____
___	___	_____	STOMACH PROBLEMS Explain_____
___	___	_____	SURGERIES What kind?_____