



Intake Form

Date: _____
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (HW) _____ (W) _____ (Cell) _____
Occupation: _____ E-mail: _____
D.O.B.: _____ Age: _____ Weight: _____ Height: _____
Marital Status: _____ Sex: M F
Allergies: _____
Supplements: _____

Bowel Movements Day: _____ Week: _____
Name of Physician: _____
Recent Surgeries: _____
Source of Referral: _____
Have you ever had a Colonoscopy? _____
Have you ever had a colonic? _____
What would you like to achieve with colon hydrotherapy? _____

Please check all that apply

- Severe Cardiac Disease (uncontrolled hypertension or congestive heart failure)
- Aneurysm
- Severe Anemia
- GI Hemorrhage/Perforation
- Severe Hemorrhoids
- Recent Colon Surgery
- Crohn's Disease
- Cirrhosis
- Fissures/Fistulas
- Advanced Pregnancy
- Abdominal Hernia
- Renal Insufficiency
- Ulcerative Colitis
- Subject to Frequent Seizures

***PLEASE NOTE: THERE WILL BE A \$30 FEE FOR ALL CANCELATIONS WITH LESS THAN 24 HOURS NOTICE.**

SIGNATURE _____ DATE _____

PLEASE CHECK ALL THAT APPLY

GENERAL

- Allergies
- Depression
- Dizziness
- Double vision
- Eating disorder
- Enlarged thyroid
- Fainting spells
- Fatigue
- Headaches
- History of cancer in family
- History of seizures
- Insomnia
- Loss of weight
- Metal toxicity

MUSCLE & JOINT

- Arthritis
- Bursitis
- Low back pain
- Neck pain
- Other joints

GENITO-URINARY

- Kidney Infection or Stone
- Painful urination
- Prostate trouble
- Kidney failure

RESPIRATORY

- Shortness of breath
- Chronic cough
- Vomiting blood
- Emphysema
- Bronchitis
- Asthma

GASTRO INTERNAL

- Colitis
- Constipation
- Crohn's disease
- Ulcerative colitis
- Diverticulitis
- Diverticulosis
- Gall bladder disease
- Hemorrhoids
- LB.S (irritable bowel syndrome)
- Fissures/fistulas
- Liver trouble
- Cirrhosis
- Rectal bleeding
- Vomiting of blood
- Cancer
- Family history of colon cancer
- Candida
- Diarrhea
- Heart burn
- Excessive belching
- Excessive gas

CARDIOVASCULAR

- High blood pressure
- Hardening of arteries
- Angina (Chest pain)
- Poor circulation
- Rapid heart beat
- Irregular heart beat
- Congestive heart failure
- Swelling of ankle

WOMEN

- Painful menstruation
- Date of last menstrual cycle ____
- Vaginal discharge
- Breast pain
- Are you pregnant? Yes/No

SKIN

- Bruise easily
- Dryness
- Itching
- Rash
- Acne
- Psoriasis

DAILY HABITS	HEAVY	MODERATE	LIGHT
Alcohol			
Coffee			
Tobacco			
Drugs			
Exercise			
Appetite			
Sleep			

PLEASE READ BEFORE SIGNING:

I have honestly answered the above questions and have not intentionally withheld information about my health.

Signature _____ Date _____