

Colon Hydrotherapy Intake Form

Name: _____ Today's Date: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

Date of Birth: _____ Marital Status: _____ # of children: _____

Emergency Contact Name: _____ Contact Number: _____

How Did You Hear About Our Services?: _____

What Do You Hope For From This Appointment? : _____

Please List Any Other Comments or Questions You Might Have : _____

Do You Have A Latex Allergy? Yes No

Current Weight: _____ Weight Six Months Ago: _____ One Year Ago: _____

Would You Like Your Weight To Be Different? Yes No If Yes , what is your ideal weight?: _____

When Did You Last Have A Physical From Your Doctor?: _____

Are you presently under a physician's care? Yes No

If yes:

For what condition?: _____

Physician's Name?: _____ Phone Number: _____

Have You Ever Had A Colonic Before?: Yes No

If Yes:

When?: _____ Where?: _____

List Any Other Types Of Cleansing Experiences: _____

Please List Medications You are Taking: _____

List Any Supplements you are taking for digestive or intestinal issues: _____

List Any Allergies you have: _____

List Any Serious Illness/ hospitalizations/ injuries: _____

What is Your Chief Health Concern?: _____

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All About Poop

How Many Bowel Movements A Day (on average) Do You Have?: _____

Are your bowel movements?: Explosive Strained Easy Other

Other, please explain: _____

What is the consistency of your Stool?: Formed Unformed Hard Runny Other

What Is The Size Of Your Stool?: Small Medium Large Pencil Thin Flat Pebbly Other

When You Eliminate What Would You Say You Feel?: Complete Incomplete Other

Other, please explain: _____

What Would You Say the Transit Time (The time it takes for a meal to pass through the digestive tract) is for you?

< 12 hours 12-24 hours 24-36 hours 2 days 3 days Don't Know

What Is The Usual Color Of Your Stool?: _____

Do You Use Laxatives?: Yes No

If yes, what types?:

Do You Have Hemorrhoids?: Yes No

Have You Had Any Rectal Bleeding?: Yes No

If Yes, Please Explain: _____

Have You Ever Had A: Barium Enema Colonoscopy Colon Surgery Rectal Surgery

Appendectomy (Removal of The Appendix) Gallbladder Surgery

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Rate the stress in your life on a scale (1= very low stress <--> 10 = totally stressed out) _____ and describe: _____

Do You Exercise Regularly? : Yes No

If Yes:

How Many Days A Week Do You Exercise?: _____

How Long On Average?: _____

What types of exercise do you enjoy?: _____

How Many Glasses Or Ounces Of Water Do You Drink Daily?: _____

What Other Liquids Do You Drink Daily (Circle All That Apply and indicate approx quantity)?:

Juice _____ Soda _____ Coffee (regular or decaf) _____ Herbal Teas (regular or decaf) _____

Alcohol _____ Protein Drinks _____ Energy Drinks _____ Other: _____

On Average What Meals Do You Generally Eat?: (Circle All That Apply) Breakfast Lunch Dinner Snacks

Circle That Which Typically Describes Your Diet:

Raw Foods Whole Foods Dairy Meat Vegan Vegetarian

Standard American Diet Fast Food Fried Foods Processed Foods

Circle The Foods That You Eat On A Daily Basis:

Starchy Vegetables Green Vegetables Beans /Legumes Fruit

Rice White Flour Whole Grains Beef Pork Meat Fish Eggs Fowl

Seeds Nuts Butter Vegetable Oils Dairy Pasta Sweets

Are You Allergic To Any Foods?: _____

What Percentage Is Your Food Home Cooked?: _____

How Many Times Do You Eat Out A Week?: _____

Do you still feel hungry after eating what you would consider a decent-size meal?: Yes No

Do You Often Get Tired After Eating? Yes No

Do You Shake, Get Light Headed Or Anxious When You Miss a Meal? Yes No

Do You Wake Up In The Middle Of The Night In A Cold Sweat Or Feeling Hungry? Yes No

Do You Sleep Well? Yes No

Please Circle Any Of The Following Supplements You Are Taking Regularly:

Fiber Acidophilus (friendly bacteria) Digestive Enzymes Essential Fatty Acids (Omega-3,6,9)

Please Circle Any Of These Conditions If They Apply Currently Or In The Past To Your Health Status:

Constipation Diarrhea Spastic Colon Irritable Bowel Syndrome (IBS) Intestinal Gas (Bloating) Headaches
Indigestion (Heart Burn / Acid Reflux) Heavy Mucus Production Skin Disorders Bad Breath Arthritis Parasites
Brain Fog (Loss Of Concentration) Chronic Fatigue Depression Kidney / Bladder Infection Backaches Weight Issues
Candidiasis (Yeast Overgrowth) Chronic Sinus Or Lung Conditions HIV Positive

For Women Only:

Are Your Periods regular?: Yes No Do You Presently Use Birth Control? Yes No

If yes, what kind of birth control are you using? _____

If no, what kind of birth control have you used in the past?: _____

Have You Had Tubal Ligation?: Yes No

Have You Had A Hysterectomy?: Yes No

Is there any possibility you are pregnant?: Yes No

Are You Trying To Conceive?: Yes No Are You Breastfeeding?: Yes No

Vitronics Disclaimer

Terms of Treatment: I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder and does not prescribe medical treatment or pharmaceuticals. It has been made clear to me that colon hydrotherapy is not a cure or substitute for medical examination or diagnosis and that it is recommended that I see a physician for any ailments that I might have. I acknowledge that I have fully and honestly disclosed my health history to the therapist. I agree that the therapist is helping me with natural hygiene at my request, and is not diagnosing, nor treating disease, nor practicing any form of medicine.

Signature: _____

A contraindication is any indication or symptom that makes it inadvisable to use a particular therapy. The following are contraindications for colon hydrotherapy. If any of these apply to you, we are not able to treat you with colon hydrotherapy at the present time.

If you have any of these contraindications you may still be eligible to receive colon hydrotherapy once they have subsided or been eliminated or if you are under the order, guidance and supervision of a qualified physician.

If you have any questions please call me at (315) 446-3918.

Cancer of the Colon or GI (gastro intestinal) Tract
Acute Abdominal Pain
Recent History Of GI or Rectal Bleeding
Congestive Heart Failure
Uncontrolled Hypertension
History of Seizures
Carcinoma Of The Rectum
Abdominal Surgery
Intestinal Perforation
Abdominal Hernia
Recent Colon Or Rectal Surgery
Diverticulitis
Recent Heart Attack
General Debilitation
Vascular Aneurysm
Renal Insufficiency
Epilepsy or Psychoses
Severe Hemorrhoids
Cirrhosis
Fissures or Fistula
Pregnancy
Ulcerative Colitis
Acute Crohn's Disease
Rectal or Abdominal Tumors
C-Diff (Clostridium Difficile)

Please place your initials below to confirm that you have read and understand all of the contraindications for Colon Hydrotherapy.

Since the therapist is not licensed to diagnose disease states, I, the client take full responsibility for the status of my health and choose of my own free will to go ahead and have a colonic session performed. I, the client, also agree to let the therapist know of any changes to my health status with regard to future bookings: *Initials _____

(It is advisable if you are not aware of the status of your health at this time to seek out the services of a competent physician prior to booking a colon hydrotherapy session.)

Cancellation Policy

I realize that the time scheduled was reserved specifically for me and I will respect the therapist's time.

****If I cancel, reschedule, or skip an appointment without a minimum of 12 hours notice, I agree to pay the full session fee.**

****If I cancel, reschedule, or skip an appointment with 12-24 hours notice, I agree to pay for half a session.**

I acknowledge that if I arrive late for an appointment, the session time may be adjusted so as not to inconvenience the next client.

By placing my initials*, I confirm my agreement to the "Cancellation Policy":

***Initials _____**

The therapist respects the client's time and agrees to the same policy above:

****In the event that the appointment is cancelled, rescheduled, or skipped – if less than 12 hours notice, the next session is free. If between 12 and 24 hours notice, the next session is half price.**

Signed: _____

Date: _____

**** Unless due to circumstances beyond our control such as severe weather conditions, natural disaster, death, etc...**

In addition, the therapist and client may verbally adjust the above policy on a per instance basis as long as both parties are in agreement.