*** Colon Hydrotherapy Confidential Intake Form***

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate your main Health Concerns in order of importance to you:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Since when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Since when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Since when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a Colonic before?   Y  N

If yes, When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was it an **OPEN** or **CLOSED** system? (Please circle)

**Contraindications for colon hydrotherapy, please mark all that apply with Yes (Y) or No (N)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Congestive Heart Failure | Y     N | Inguinal Hernias | Y     N | Aneurysm | Y    N |
| Uncontrolled High BP | Y     N | Rectal Fistulas | Y     N | Rectal Bleeding | Y    N |
| Abdominal Surgery (past 6 months) | Y     N | Colon/Rectal Tumours | Y     N | Kidney Insufficiency | Y    N |
| Active Colitis  | Y     N | Active Crohn's | Y     N | Diverticulitis | Y    N |
| Abdominal Tumours or Cysts | Y     N | Pregnancy | Y     N | Abdominal bruising | Y    N |
| Liver Cirrhosis | Y     N | Hemorrhoids | Y     N | Intestinal Perforations | Y N |

**Do you experience other digestive difficulties/disorders, please mark with Past (P) or Current (C)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Abdominal Pain | P    C | Belching | P    C | Bloating | P    C |
| Acne/Boils | P    C | Depression | P    C | Overweight | P    C |
| Allergies/Hives | P    C | Diarrhea | P    C | Parasites | P    C |
| Asthma | P    C | Diverticulitis | P    C | Polyps | P    C |
| Bad Breath | P    C | Eczema | P    C | PMS | P    C |
| Dark Circles under Eyes | P    C | Fatigue | P    C | Psoriasis | P    C |
| Offensive Body Odour | P    C | Fibromyalgia | P    C | Cancer | P    C |
| Blood in Stool | P    C | Gallstones | P    C | Rectal Fissures | P    C |
| Rashes/Skin Issues | P    C | Headaches | P    C | Rectal Itch | P    C |
| Crohn's Disease/Spastic Colon | P    C | Heartburn | P    C | Rosacea | P    C |
| Coated Tongue | P    C | Hemorrhoids | P    C | Sinusitis | P    C |
| Colitis | P    C | IBS | P    C | Ulcers | P    C |
| Constipation | P    C | Nausea | P    C | Vomiting | P    C |
| Diabetes | P    C | Appendicitis | P    C | Kidney Stones | P    C |
| Gas | P    C | Joint Pain | P    C |  |  |

**EMOTION**

What is your current level of stress? High \_\_\_\_\_\_\_\_ Moderate \_\_\_\_\_\_\_\_ Low \_\_\_\_\_\_\_\_

How many hours of sleep do you get per night on average? <5 \_\_\_\_\_\_\_\_ 6-8 \_\_\_\_\_\_\_\_ >8 \_\_\_\_\_\_\_\_

Do you wake feeling rested? Y N

Do you experience (YorN): Mood Swings \_\_\_\_\_\_\_\_ Depression \_\_\_\_\_\_\_\_ Anxiety \_\_\_\_\_\_\_\_ PMS \_\_\_\_\_\_\_\_

**CHEMICAL**

Are/were you a smoker? Y N If yes, how many daily? \_\_\_\_\_\_\_\_ How Long? \_\_\_\_\_\_\_\_

If you quit, when? \_\_\_\_\_\_\_\_\_\_

Do you wear: perfume/cologne? Y N Deodorant Y N Hair Product Y N

Do you take antibiotics at least once a year? Y N

List any medications you are currently taking (prescription and over the counter) along with the reason you are taking it. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIET**

Are you on a cleanse or special diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a vegetarian/vegan? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much of the following do you drink daily? (cups) Water \_\_\_\_\_ Coffee \_\_\_\_\_ Black Tea \_\_\_\_\_

Herbal Tea \_\_\_\_\_ Juice \_\_\_\_\_ Pop \_\_\_\_\_ Alcohol \_\_\_\_\_ Beer \_\_\_\_\_ Wine \_\_\_\_\_

How many times in a week do you eat the following foods? Beef \_\_\_\_\_ Pork \_\_\_\_\_ Chicken \_\_\_\_\_

Eggs \_\_\_\_\_ Fish \_\_\_\_\_ other meat \_\_\_\_\_ Nuts \_\_\_\_\_ Fruit \_\_\_\_\_ Vegetables (raw) \_\_\_\_\_ (cooked) \_\_\_\_\_\_\_

Do you eat Organic fruits/vegetables? Y N

Dairy \_\_\_\_\_\_ Baked goods \_\_\_\_\_ Beans \_\_\_\_\_ White flour products (rice, bread, etc) \_\_\_\_\_

Whole grains (quinoa, brown rice, oats, barley, etc) \_\_\_\_\_\_\_\_

Do you have any food allergies? (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What foods do you crave? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any supplements daily? If yes, please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STOOL INDICATORS**

The following are helpful indicators of the health of your bowels as well as your overall health. Under each heading please circle all responses that apply to you over the last 3 months.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Frequency** | **Consistency** | **Contents** | **Length** | **Width** | **Texture** | **Colour** | **Time** |
| Daily1x, 2x, 3x | Hard, dry | Mucous (white/yellow) | 6” or more | 3” + tubular | Smooth, well formed | Light to dark brown |  1 min or less |
| Every 2 days | Firm | Fat floating | 3-5” pieces | 1” tubular | Thready, loose | Orange, yellow brown | 1-5 mins |
| Weekly | Soft | Blood | Less than 3” | Dime thin or less | Lumps pressed together | Grey/green | 5-15 mins |
| Once a week or less | Loose/watery | Food particles | Chunks/balls | Varies | Varies | Black | 15+ mins |

I, the undersigned, hereby acknowledge that the personnel at The Lakeside Clinic are not prescribing (ordering for use as medicine) for me at any time, and I will not hold them accountable for such. Any recommendations I receive are not intended as primary therapy for any symptoms or disease, but as a means of enhancing the quality of my diet. I understand that colon hydrotherapy is a professional service, which may provide information related to nutritional requirements, however this service is not a tool for the prevention, assessment or diagnosis, or treatment or any particular illness or disease. The services I receive are initiated at my own request for reasons personal to me. I understand that all sessions and series I purchase are non-refundable and cannot be transferred to a family member or friend at anytime. I am responsible to be at my scheduled appointment on time. If I miss or cancel my appointment without giving 24 hours notice I agree to be charged a $50 late cancellation fee by The Lakeside Clinic.

**Client Signature**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**