

# A Healthy Practice

## Client Intake Form

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:**

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

# 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	
<b>Total Toxicity Score</b>	

## 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