Brampton Colonics & Allergy Centre
Confidential Intake Form

Date: _____ Referral source: _____
Name: _____ Date of birth: _____
City: _____ Postal code: _____ Phone #:_____
E-mail : _____ Occupation: _____

What symptoms or health concern brings you to this appointment? _____

_____

Please list any disease, illness or ailments you have been diagnosed with:_____

_____

Have you been hospitalized (births), surgery, or any organ(s) removed?_____

_____

Contraindications for colon hydrotherapy, please mark all that apply with Y or Circle N for none

Fissures or Fistula _____ **Colon Cancer** _____ **Surgery**_____ **Renal Failure** ____ **Liver cirrhosis** _____

Hemorrhoids _____ **Heart Failure** _____ **Hernia** _____ **Are you pregnant?** _____ **Intestinal perforation** ____

Other digestive disorders please mark with a Y or N: IBS _____ Colitis _____ Crohn's _____ Ulcer _____

Diverticulitis____ Diabetes _____ Polyps ____ Gallstones _____ Appendicitis _____ Kidney Stones _____

List any medication you are currently taking (prescription and over the counter).

_____

_____

Do you take the following daily: Multi-vitamin_____, Probiotic _____, Magnesium _____, Omega 3 _____, Vit. C _____
Other supplements: _____

Emotions: What is your current level of stress? Minimal ____ Average _____ Considerable _____

How many hours of sleep do you get/night? _____ Do you wake feeling rested? _____

Do you experience (Y or N): Mood Swings? _____ Depression? _____ Anxiety? _____ PMS? _____

Chemicals (Yes or No): Are/were you a smoker? _____ How many daily? _____ For how long? _____

If you quit, when? _____ Do you take antibiotics at least once/year? _____Drink tap water?_____

Eat organic fruit and vegetables?_____ Have you travelled in the last year? _____

Did you get sick on the trip or upon returning home?_____ Do you use antacids? _____

Have you done a parasite cleanse? _____ When?_____

Do you use laxatives? _____ What kind and how often? _____

How much of the following do you drink daily? Water ____(glasses) Coffee _____ Juice ____ Herbal tea ____ Pop ____

How many times in a week do you eat the following foods? Alcohol____ Dairy _____Nuts ____ Fruit _____

Meat (beef/chicken/eggs/fish) _____ Vegetables (raw) _____ (cooked) _____ Beans _____ Baked Goods ____

White Flour products (rice, bread) ____ Whole grains (quinoa, brown rice, oats) _____ Are you a vegetarian/vegan? _____

Do you have any food allergies? _____

What foods do you crave? _____

Do You Exercise? _____ **How many times a week?** _____ **How long (30 min, 1 hr)?**_____

In an average day what do you eat?

Breakfast _____

Lunch _____

Dinner _____

Do you experience digestive difficulties (please check all those that apply):

Bloating ____ , Constipation _____ , Heartburn____ , Gas ____, Burping _____, Diarrhea _____, Fatigue ____,

Abdominal pain ____, Headaches ____, Joint Pain ____

Stool Indicators: Under each heading please circle all responses that apply to you in the last month.

Frequency	Consistency	Contents	Length	Width	Texture	Colour	Time On toilet
Daily (circle 1) 1x - 2x - 3 x	Hard, dry	Mucous	8" or more	3"+ tubular	Smooth, Well formed	Light to dark brown	5 min or Less
Every 2 days	Firm	Fat floating	3-5" pieces	1" tubular	Thready, loose	Orange/ Yellow brown	5-15 min.
Weekly	Soft	Blood	Less than 3"	thin or stringy	Lumpy balls	Grey/Green	
Once/wk or less	Loose/Watery	Bits of food	Pellets /balls	Varies	Varies	Black	

I, the undersigned, hereby acknowledge that the personnel at Brampton Colonics & Allergy Centre 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 symptom 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 of 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 but can be transferred to a 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 pay a $25 late cancellation fee to Brampton Colonics & Allergy Centre.**

Client signature _____ **Date** _____
