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? :____

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____

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:____

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

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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 Varies Other

Other, please explain:____

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

What Is the typical size of your Stool?: Small Medium Large Pencil Thin Flat Pebbly Varies

When You Eliminate What Would You Say You Feel?: Complete Incomplete Varies 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 No Clue

What Is The Usual Color Of Your Stool?: ____

Do You Use Laxatives?: Yes No

If yes, what types?:

Do You Have Hemorrhoids?: Yes No Sometimes Not Sure

Have You Had Any Rectal Bleeding?: Yes No Sometimes

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

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 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 Sometimes

Do You Often Get Tired After Eating? Yes No Sometimes

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

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

Do You Sleep Well? Yes No Sometimes

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

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

Vitonics 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. I give my permission for the

colon hygienist to insert the colonic scope into my rectum and administer the colonic.

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.