

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone Home _____ Office _____ Status S M D W Children Y N

Weight _____ Height _____ DOB _____ Age _____ Occupation _____

Email & Web Address _____

How did you hear about me? _____ Blood Type _____

Have you received colon hydrotherapy? _____ Date _____ Results _____

What is your overall health goal? _____

What is your reason for treatment? _____

Have you had a barium X-ray? _____ Colonoscopy? _____ Dates? _____

Reason and results _____

What other therapies are you using? _____

Insurance/Health Care Provider _____ Primary Physician _____

Fluids

What is your total fluid intake per day in quarts? _____

Underline your main beverages: water: tap distilled RO other herb teas raw juices bottled juices coffee tea beer wine alcohol soft and diet drinks Do you have a juicer? Y N If yes, what kind? _____

Do you drink with meals? _____ What? _____ Quantity? _____

Exercise

What is your workout routine? Types of exercise _____

Length of workout _____ Days practiced _____

Circle Does exercise come *easy* or *hard*? _____ Did you have physical training as a child? Y N

Diet

Have you fasted? Y N Percentage of diet from fruits and vegetables? _____ % living foods _____ %

Do you practice food combining? Y N *Circle*. Do you crave: sugar salt carbonation chocolate fat?

What *percentage* of the time do you eat out? _____ % order out? _____ %

Have you eaten the following in the past year? *Circle for Yes*.

beef	cheese	pizza	whitebread	worchestershire
pork	cream cheese	icecream	waffles	nutrisweet
lamb	sour cream	pie	popcorn	msg
chicken	cottage cheese	candy	cereal	equal
fish	whipping cream	cookies	frenchtoast	ranch dressing
turkey	miraclewhip	donuts	englishmuffins	soysauce
cold cuts	mayonnaise	cake	bagels	olestra or olean
eggs	kefir	pastries	frenchfries	tartarsauce
butter	yogurt	pancakes	chips	catsup
margarine	milk	pretzels	salt	mustard

Eating Behaviors

Circle any behaviors you experience(d). overeating bingeing anorexia bulimia bulimorexia late night eating eating when fatigued in pain constipated emotionally upset not hungry

Do you feel food addicted? Y N Do you eat slowly and chew well? Y N

Are you able to eat and drink what you intuitively feel is right for you? Y N

Intestinal Conditions

Initial any you experience(d). N = Now and P = Past

fatigue after eating	diarrhea & constipation	prolapsus/redundancy	ulcer
hungry all the time	atonic colon	colitis/mucus/ulcerative*	perforation
lactose intolerance	gripping/cramping	diverticulosis/itis*	fissure**
indigestion	acute fecal impaction*	spastic colon	fistula**
gas	hard stool	IBS	hernias**
bloat	parasite infection*	celiac disease	rectal pain
reflux/heartburn	black stools	crohn's disease*	hemorrhoids**
constipation	intestinal/rectal bleeding	anal/rectal	colon /rectal carcinoma
diarrhea		itching/burning	colon/rectal surgery**

How often do you eliminate? Times Daily _____ Weekly _____

Initial any you use(d). N = Now and P = Past

psyllium bentonite laxatives enemas colemas enzymes flora stool softener antiacids
 Brand name _____ Dates _____

Circle the appropriate. My bowel movements are:

spontaneous occur only after eating effortless require straining painful incomplete

Do you have any family history of intestinal problems? Y N What? _____

Other Conditions

Initial any you experience(d). N = Now and P = Past

bleeding gums	allergies	foot fungus	Parkinsons	water retention
aneurysm**	cancer	skin itching/rashes	Bell's Palsy	interstitial cystitis
earache	RA MS or arthritis	eczema	stroke	pms
headache	candida/monilia	hypoglycemia	insomnia	irregular periods
migraine	fybromyalgia	diabetes	heart disease**	endometriosis
body odor	CFS EBV	hepatitis/cirrhosis**	varicosity	uterine fibroids
bad breath	lupus	nausea	hypo/hyperthermia*	pregnancy (mos?)*
fever	aids	vomiting	cold hands feet	abortion
chancere sores	renal insufficiency**	backache	bruise easily	cysts
sinusitis	psoriasis	shoulder pain	cuts heal slowly	menopause
asthma	shingles	joint/muscle pain	anemia**	STD
seizures	herpes	swollen prostate	hypertension**	infertility
chemical sensitivity	urination difficulties	impotency	inability to lose weight	accident injury or trauma

Surgeries

Circle and date operations: gall bladder uterus ovaries prostate intestines spleen C-section
 laparoscopy liposuction appendix tonsils rectocele cystocele back cyst tubal ligation vasectomy
 ectopic pregnancy Other _____

Emotional Mental States

Circle any you experience(d) excessively.

depression irritable restless codependent grief anger hurt sad forgetful anxious fearful despair
 victim of sexual or other abuse mental confusion obsessive compulsive bipolar suicidal

Are you under excessive stress? Y N How do you respond to stress? _____

Supplements and Drugs

List herbs, vitamins, supplements used _____

List over the counter medication used _____

List prescription medication used _____

Does any of your medication slow or speed your elimination? Name _____ Effect _____

Initial substances you use(d). N = Now and P = Past

marijuana cocaine heroin meth nicotine barbiturates sedatives birth control pills hormones steroids other

Rates, Policies and Disclaimer for Colon Hydrotherapy

Effective April 19, 2007

Rates for Sessions

\$75 for One-Hour Session

Series Prices For Payment In Advance

A Series is a Commitment to You and Your Health!

\$216 for 3 (\$72)

\$350 for 5 (\$70)

\$536 for 8 (\$67)

\$650 for 10 (\$65)

Series must be used within five months

No Refunds Are Available with Series

Series are non-transferable

Rates for Implants and Additives

Implants \$30

(Additional 30 minutes required)

Additives \$10

Additives and Implants Are Supplied by Client

Physician Prescription Required

Additional Policies

24 Hour Cancellation Is Required for Any Appointment or
You Are Charged for the Full Amount.

\$35 Return Check Fee

Credit Cards Are Accepted

Disclaimer - Colon Hydrotherapy is not intended to replace the relationship with your primary health care providers and my consultation is not intended as medical advice. They are intended as a sharing of knowledge and information from my education, research, experience and community. As a Colon Hydrotherapist, I encourage you to be open to new information on the effectiveness of colon hydrotherapy and the foundational role of diet, exercise, supplementation, stress management and emotional and mental work. I encourage you to make your own health care decisions based upon your research and in partnership with your primary health care providers.

The information and service provided is not used to prescribe, recommend, diagnose or treat a health problem or a disease. It is not a substitute for medical care. If you have or suspect you may have a health problem, you should consult your primary health care providers.

Name _____ Date _____