

Colonic Institute OF WEST HARTFORD



Client Intake Form

Date _____			
NAME _____		PREFERRED NAME OR NICKNAME? _____	
ADDRESS/CITY/ZIP _____			
TELEPHONE (PROVIDE MINIMUM OF TWO): HOME _____		WORK _____	CELL _____
EMAIL _____		REFERRED BY _____	
HEIGHT _____	WEIGHT _____	BIRTH DATE _____	BIRTH SIGN _____

Are you currently under a MD or ND's Care? If yes, please explain:

Doctor's Name: Telephone

Are you pregnant? What is your Blood Type? (if you know it)

List of all known allergies:

List of all surgeries within the last 5 years:

List all medications:

Do you currently take a Pro-biotic Supplement?

Please put an **(X)** beside anything that is CURRENTLY a health challenge. Put **(P)** beside a past problem:

- | | | | |
|--------------------------------------|--|---|---|
| <input type="radio"/> Constipation | <input type="radio"/> Arthritis | <input type="radio"/> Diabetes | <input type="radio"/> Antibiotic uses |
| <input type="radio"/> Diarrhea | <input type="radio"/> Headaches | <input type="radio"/> Sinus problems | <input type="radio"/> Prostate problem |
| <input type="radio"/> Hemorrhoids | <input type="radio"/> Dizziness | <input type="radio"/> Herpes | <input type="radio"/> Liver/gallbladder issue |
| <input type="radio"/> Indigestion | <input type="radio"/> Allergies | <input type="radio"/> Parkinson's | <input type="radio"/> Urination problems |
| <input type="radio"/> Belching | <input type="radio"/> Parasites | <input type="radio"/> C.F.S/immune disorder | <input type="radio"/> Breast implants |
| <input type="radio"/> Flatulence/gas | <input type="radio"/> Yeast infections | <input type="radio"/> Cancer | <input type="radio"/> Psyche disorders |
| <input type="radio"/> Ulcers | <input type="radio"/> Insomnia | <input type="radio"/> Cysts/tumors | <input type="radio"/> Dental issues |
| <input type="radio"/> Colitis | <input type="radio"/> Irritability | <input type="radio"/> Birth control pills | |

Bowel Habits and Elimination

How often do you have a b/m?: PER DAY? PER WEEK?

Are they spontaneous? (please circle one): ONLY AFTER EATING REQUIRES STRAINING EFFORTLESS

Do you have hemorrhoids? (please circle): YES NO Have you ever had rectal bleeding, if yes, when?

Do you use a laxative? Herbal laxative? Stool softener? Suppositories? Enemas?

(over)

Diet

List all supplements you are CURRENTLY taking:

Mark "Y" for YES and "N" for NO. If YES, list amount and frequency:

..... Coffee

..... Sugar/salt cravings.....

..... Teas.....

..... Plain water intake per day.....

..... Carbonated drinks/soda.....

..... Vegetarian/Vegan

..... Diet programs (ATKINS, SOUTH BEACH, RAW FOODS ETC.).....

General

Exercise (type and frequency)

Yoga/Meditation

Wheat and dairy products

Have you have dental work done in the last 6 months?

How many silver/mercury fillings do you have in your mouth?

On a scale for 1-10, what is your commitment level to getting healthy (10 being the highest commitment)

What do you hope to achieve for this appointment?

Cancellation Policy

Cancellations or changes to scheduled appointments must be made at least 24 hours in advance of the scheduled appointment. Otherwise, you will be billed for the cost of service as a cancellation charge.

If you are calling after business hours, please leave a message on our voicemail indicating your appointment cancellation. The same charge will apply for missing an appointment. Thank you.

Disclaimer: Colon Hydrotherapy is not intended to replace the relationship with your primary health care providers and my consultation is not intended as a Colon Hydrotherapist is not intended as medical advice. They are intended as a sharing of knowledge and information from my education, research, training, and experience. As a Colon Hydrotherapist, I encourage you to be open to new information on the effectiveness of colon hydrotherapy and the fundamental 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, ND, MD or otherwise. **The information and service provided is not used to prescribe, recommend, diagnose or treat a health problem or disease. It is not a substitute for medical care.**

I have read and understand the Cancellation Policy and Disclaimer Information,

.....
SIGNATURE/DATE

Please note: Full charge for less than 24 hours notice to change or cancel appointment.

