COLON HYDROTHERAPY INTAKE FORM

This form was provided for use by VISION OF HEALTH.

Please complete the following questions carefully. All data is confidential to ensure your privacy

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation _____ Employer _____

Birth Date _____ Height _____ Weight _____ Female ____ Male _____

Marital Status Single _____ Married _____ Divorced _____ Widowed _____

#Children _____

Home # _____ Work # _____ Cell # _____

Email address _____ May we contact you at this address? _____

Would you like to receive newsletters? Yes _____ No _____

Emergency Contact _____ Phone # _____

How did you learn about our service? Personal referral _____ Doctor/Practitioner _____

Print Ad _____ Internet _____ Yellow Pgs _____ Other _____

Who may we thank for the referral? _____

Medical Care: Date of most recent visit to a Primary Care Physician (PCP) _____

Are you currently receiving healthcare by a MD/ND/Homeopath doctor (s)?_____

If so, please explain: *(Blood Sugar or Thyroid issues, High Blood Pressure or Cholesterol issues, etc.)* _____

_____

_____

Do your records need to be shared with others? _____ If yes, Whom? _____

Is Colon Hydrotherapy part of a protocol that a doctor or other healthcare professional has referred or

Prescribed for you?_____

_____

Doctor's Name _____ When? _____

Type of doctor PCP ____ gastrointestinal doctor _____ Proctologist _____ other _____

COLON HYDROTHERAPY INTAKE FORM

Why? _____

_____

Outcome _____

_____

Allergies: List all known: _____

_____

Health concerns: List top _____

_____

Parasites_____ Do you know you have parasites?_____ If yes, Describe:_____

Back Issues: _____ Do you have any problems/pain in the lower back (lumbar region)? _____

If yes, describe _____

Abdominal area surgeries: *Circle all that applies* C-Section Gallbladder Gastric Bypass Hysterectomy

Lap Band Vaginal Mesh Other _____

If yes, to any of the above, do you feel that you have had a change in bowel habits? _____

Colonic History: Have you ever had a Colonic before? _____ If so, when? _____

Where? _____

If yes, please describe your experience: _____

_____

Type of device used (Colonic system) *circle all that applies.* Closed Open Gravity Not Sure

Other forms of cleansing you are using or have used: _____

Digestion: How is your digestion? *Circle all that applies.*

Adequate Poor Acid Reflux Bloating Burning/pain in stomach Indigestion Ulcers

If other complaints described _____

_____

Have you seen a doctor about them? _____

Medications & Supplements: List all you now take regularly including over the counter _____

_____

Do you take digestive aids? _____ If yes, describe: _____

When was the most recent time you took antibiotics? _____ Why? _____

_____

COLON HYDROTHERAPY INTAKE FORM

Bowel Habits: How often do you have a bowel movement? 3 per day 2 per day 1 per day skips days

How are your bowel eliminations normally? *(Circle the best response)* Requires Straining Effortless

When? Only after eating Varies (Describe)_____

Amount: normal too little too large **Consistency:** normal too hard very soft diarrhea

Color: brown black whitish greenish **Other:** lot of mucus lots of gas foul smell

Is the gas related to certain food (s)? _____ If so, describe:_____

Do you have bowel problems? _____ Do you feeling your bowel movements are incomplete? _____

Describe complaints: _____

_____

Have you seen a doctor about them? _____

Do you use a stool softener or laxative? _____ Herbal laxative? _____ Suppository?_____

Product name (s): _____

If yes, how often? _____ If yes, used for how long (days, months, years)? _____

Do you have hemorrhoids or other rectal problems (itching, fissures, etc.)?_____

If yes, describe: _____

If yes, have you been seen by a doctor? _____

CONTRAINDICATIONS FOR COLON HYDROTHERAPY:

Abdominal Hernia, Acute Crohn's Disease, Acute Ulcerative Colitis, Carcinoma of the Rectum, Cirrhosis, Congestive Heart Failure, Divertucilitis, Epilepsy, History of Seizures, Intestinal Perforation, Kidney Insufficiency, Pregnancy, Recent Heart Attack, Recent Surgery, Rectal Bleeding, Rectal Tumor, Severe Fissures or Fistula, Severe Hemorrhoids, Vascual Anueurism

Energy: On a scale from 1 to 10 where 1= "can't get out of bed" and 10= "optimal energy"

Please rate your normal energy level: _____ Any relation to food or drinks?_____

If yes, describe examples: _____

Diet: What type of diet best describes your **general dietary habits?** *(Circle the best response)*

Junk food/fast food eater combination (from junk food to health conscious) vegetarian

Vegan raw macrobiotic natural food eater (over 50% organic) health conscious

How many servings of **fruits** do you eat per day? _____

How many servings of vegetables do you eat per day? Raw_____ Cooked _____

COLON HYDROTHERAPY INTAKE FORM

How much **dairy** do you eat per day? _____ How much **meat** do you eat per day or week? _____

Dietary Goal: My diet **goal** is to be: *(Circle the best response)*

Combination (from junk food to health conscious) Vegan raw macrobiotic Vegetarian

Natural food eater (over 50% organic) Health conscious

Water: How much water do your drink per day? _____ glasses or _____ ounces

Water Source: Tap (from city or well) Bottled Filtered Boiled Whatever is available

Describe your typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Smoking: Do you currently smoke?_____ If yes, how much? _____ How long? _____

Alcohol: Do you currently drink? _____ If yes, how much? _____ How long? _____

Stress: On a scale from 1 to 10 where 1 = "is mellow" and 10 = "Stressed Out"

Please rate your current stress level: _____ what are the main source of your stress? _____

_____

If you're stress, level 5 or more, what step (s) are you taking to reduce your stress? _____

_____

Do you notice changes in your bowel habits when you make any changes to exercise, diet, water intake, and stress?_____ If so, please explain: _____

_____

For women pre-menopausal: **Monthly cycle:** Do you experience PMS?_____

Are your periods more than 6 days? _____ Are you susceptible to chronic yeast infections? _____

What do you hope to achieve from this colon hydrotherapy appointment? _____

_____

Do you have any specific concerns? _____ If yes, explain: _____

_____

My signature below indicates I have honestly answered all of the questions above and supplied any additional relevant information within this intake form.

_____ Date: _____

Client Name (Signature)

_____

Client Name (Printed clearly)

****Reminder: Please stop eating 2 hours prior and stop drinking 1 hour prior to your appointment****

COLON HYDROTHERAPY INTAKE FORM

Financial and Cancellation Policy

Single Session (Initial Visit) **$95.00 ea**
Package of 3 (Initial Pre-Paid) **$225.00 ea**
Missed Appointments: $95.00 or a session deducted from your pre-paid package.

An initial appointment, which includes a consultation and colon hydrotherapy session, will take approximately 1 ½ hours. Follow up session last approximately 1 hour. There may be supplements recommended to complement and enhance the process of cleansing, detoxifying and rebalancing the system these supplements are an additional cost. All payments are due at the time of the visit.
Packages must be used within 3 months from the time of purchase.

Your time is valuable and we appreciate your understanding that our time is valuable as well. If you don't show up for your appointment or if less than 24 hours notice is given to change or cancel an appointment, you will be charged a fee of $75. For the missed appointment. Your willingness to cover the cost of a missed appointment when you cannot give 24-hour notice clearly demonstrates your consideration of our time and efforts. (Special circumstances are considered on a case-by-case basis).

RELEASE STATEMENT:
I acknowledge that Melinda Smith by *VISION OF HEALTH* is not a medical doctor. I understand that *MELINDA SMITH* may provide nutritional and other health related information to help me attain and maintain my best health. All suggestions are designed to help me move towards my best state of health through personalized recommendations in lifestyles, exercise, health habits and advanced nutrition. I understand that *VISION OF HEALTH* do **NOT** diagnose, treat, or claim to cure any illness or disease.

I have been made aware of all contraindications for colon hydrotherapy and am here on this day and any subsequent visit by my choice and solely on my own behalf. I hereby release and discharge Melinda Smith with *VISION OF HEALTH* from any and all claims which I or my agents ever had, now have or may have relating to or arising out of services provided or recommendation that I have received. I acknowledge that it is my responsibility to consult with my physician or other health care providers relating to any disease or condition that I may have.

I have read this informed consent and understand it. I am not a minor (under the age of 18).

I understand the above Financial & Cancellation Policy and will abide by these charges.

I am signing this release voluntarily.

_____ Date: _____
Client Name (Signature)

_____
Client Name (Print clearly Please)