

COLON HYDROTHERAPY CLIENT INFORMATION

Today's Date: _____ Date of Birth: _____ Age: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phones: - Home: _____ Office: _____ Cell: _____

Email Address (please write clearly): _____

Occupation/Employer: _____ How did you find out about us? _____

Emergency Contact: _____ Phone Number: _____

Have you had a colonic before? _____ If so, when? _____

How many times a day or week do you have a bowel movement? _____

Have you ever been treated for pathology of the colon? _____

When have you observed blood in your stool? _____ Have you ever observed mucus in your stool? _____

Do you experience diarrhea or constipation? Please describe: _____

Do you have any immune disorders? HIV+ _____ AIDS _____ Other _____

Do you have family history of colon problems? _____ Please describe: _____

How do you feel today? _____

Please describe any surgery: _____

List all medications and Prescribing Doctors: _____

Do you have high blood pressure? _____ Low blood pressure? _____

What symptoms would you like to improve? _____

Please list the foods you've eaten in the past 24 hours: Breakfast: _____

Lunch: _____

Dinner: _____

Other: _____

Is this your typical diet? _____ What snacks & food do you crave? _____

Do you eat late at night? _____ Describe: _____

Is your diet high in fiber or bulk? _____ What kinds? _____

Do you take Laxatives? _____ What types? _____

Do you take any dietary supplements or herbs? Please describe (pills, liquid extract, tea, brand name): _____

When was the last time you took antibiotics? _____

Please check all of the following that you've had in the past week: _____ Coffee _____ Alcohol

_____ Soda _____ Black Tea _____ Sugar _____ Tobacco

Do you sleep well? _____ How many hours nightly? _____

What are the stresses in your life? _____

What activities help with stress reduction? _____

How often do you do these activities? _____

What are you hoping to attain from your Colon Hydrotherapy sessions? _____

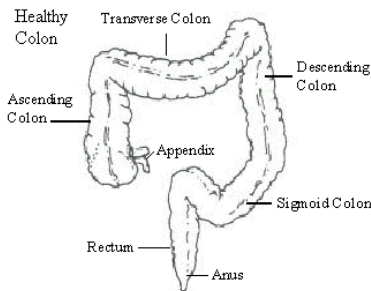
COLON HYDROTHERAPY CLIENT INFORMATION CONTINUED...

Please mark Yes or No for the following conditions. If it was a health concern in your past, mark 'P' and the year.

Are you pregnant? _____	If so, how many months? _____
Ever had a Sigmoid or Colonoscopy? _____	If so, when? _____
Who was your doctor? _____	Do you have diabetes? _____
Acute Fecal Impaction _____	Parasitic Infections _____
Irritable Bowel Syndrome _____	Constipation _____
Colitis _____	Mucous Colitis _____
Diverticulosis (Pocket Outward Pouching) _____	Diverticulitis (Infected Pocket) _____
Hyper / Hypothermia _____	Kidney Insufficiency or Failure _____
Crohns Disease _____	Ulcerative Colitis _____
Severe Hemorrhoids _____	Acute Fistula _____
Rectal Fissure _____	Intestinal Ulcers _____
Bleeding Colitis _____	Aneurysm _____
Gastro-Intestinal Hemorrhage or Perforation _____	Recent Abdominal Liposuction _____
Recent Colon or Rectal Surgery _____	Other Recent Surgery _____
Abdominal Radiation _____	Acute Inflammatory Pathology of the Colon _____
Congestive Heart Failure _____	Cirrhosis of the Liver _____
Hypertension _____	Is it controlled? _____

If yes, what was your last blood pressure reading? _____

Please shade in any areas that are a current or past concern on the below diagram:



Who would NOT be a candidate for colon hydrotherapy treatments? If you have a concern about your health or the appropriateness of colon hydrotherapy you should consult a doctor. If you are diagnosed with Diverticulitis, ulcerative colitis, Crohns disease, severe hemorrhoids, rectal or intestinal tumors, have undergone recent radiation therapy, have uncontrolled hypertension, congestive heart failure, or organic valve disease, have an aneurysm, severe anemia, GI hemorrhage/perforation, cirrhosis of the liver, fissures or fistulas, have an abdominal hernia, have had recent colon surgery or renal insufficiency then you would **NOT** be a candidate for colon hydrotherapy treatments. Pregnant women are also advised to only receive colon hydrotherapy during the second trimester of their pregnancy and under the direct supervision and advice from their physician. Professionally administered colon hydrotherapy is generally safe if you are free of the above cited conditions/contraindications.

- DISCLAIMER - Every therapy, service, and product described or presented at Center for Integrated Medicine is NOT a cure for any disease, ailment, or health condition. NO MEDICAL CLAIMS are expressed or implied, either directly or indirectly, regarding the therapies, products, or services presented herein.

I, _____ agree that the above information is accurate to the best of my knowledge. I give Center for Integrated Medicine permission to share information with the prescribing doctor, and evaluate and provide colon hydrotherapy. I am aware of and do not have contraindications. I have received a copy of Center for Integrated Medicine Policies, as well as a list of the contraindications for colon hydrotherapy and I hereby agree that I am responsible for my health and the services received here. I am aware of my 9th Amendment Rights to practice alternative health modalities.

Your Signature _____ Date _____

Prescribing Doctor _____ Phone Number _____