HEAVENLY WHOLE
COLONIC THERAPY

CLIENT INFORMATION & MEDICAL HISTORY INTAKE FORM

PERSONAL HISTORY *(Clients under age 17 - signature and attendance of parent or guardian is required.)*

Name: _____ DOB: _____ / _____ / _____

Age: _____ Height: _____ Weight: _____ Email Address: _____

Address: _____ City: _____

State: _____ ZIP: _____ Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Emergency Contact

Name: _____ Phone: (_____)_____

How were you referred to have Colon Hydrotherapy session(s)? Please check all that apply.

☐ Doctor Referral ☐ Friend ☐ Social Media ☐ Digital ☐ TV ☐ Brochure

☐ Sign ☐ Desire for better colon health

Reason for visit: _____

MEDICAL HISTORY

Do you have any communicable diseases?

☐ Yes ☐ No Explain: _____

Contraindications: In the last six months, have you been diagnosed with or suspect you have the following? Please check all that apply.

☐ Abdominal Surgery
☐ Abdominal Hernia
☐ Anemia
☐ Crohn's Disease
☐ Carcinoma of the Colon
☐ Cirrhosis
☐ Diverticulitis
☐ Fissures/Fistulas
☐ Hemorrhaging
☐ Hemorrhoidectomy
☐ Intestinal Perforations
☐ Recent Colon/Rectal Surgery
☐ Lupus
☐ Renal Insufficiency
☐ Congestive Heart Failure
☐ Severe Hemorrhoids
☐ Carcinoma of the Rectum

Are you under the care of a primary physician?

☐ Yes ☐ No Explain: _____

List any medications by name and dosage, including digestive aids/laxatives:

_____

_____

Do you take steroids or blood thinners? ☐ Yes ☐ No Explain: _____

HEAVENLY WHOLE
COLONIC THERAPY

MEDICAL HISTORY *Continued*

Please check all that apply:

- ☐ Use Laxatives
- ☐ Hemorrhoids
- ☐ Rectal Surgery
- ☐ Colon Surgery
- ☐ Recent Barium Enema
- ☐ Recent Colonoscopy
- ☐ Alcoholic
- ☐ Asthma
- ☐ Bad Breath
- ☐ Bladder Infection
- ☐ Bloating
- ☐ Blood in stool
- ☐ Bronchitis
- ☐ BM Painful/Difficult
- ☐ Other:

- ☐ Burning Stomach Sensations
- ☐ Burning/Itching Anus
- ☐ Cardiac Condition
- ☐ Chronic Fatigue
- ☐ Colitis
- ☐ Constipation
- ☐ Depression
- ☐ Diarrhea
- ☐ Dialysis Patient
- ☐ Difficulty Sleeping
- ☐ Diverticulum
- ☐ Extreme Stress
- ☐ Gas/Stool Very Foul Odor
- ☐ Hepatitis B or C

- ☐ High Blood Pressure
- ☐ Hungry Between Meals
- ☐ Infectious Disease
- ☐ Irritability
- ☐ Irritable Bowel Syndrome
- ☐ Indigestion After Meals
- ☐ Malignant Condition
- ☐ Parasites
- ☐ Recent Barium/Colonoscopy
- ☐ Recent Surgery
- ☐ Rectal Bleeding
- ☐ Swollen Ankles
- ☐ Sour Stomach Frequently
- ☐ Vomiting

On a scale of 1-10 where 1 = don't exercise and 10 = exercise daily, describe your activity level: _____

On a scale of 1-10 where 1 = can't get out of bed and 10 = optimal energy, describe your energy level: _____

How many servings/day do you eat or drink? Vegetables: ____ Fruit: _____ Meat: _____ Dairy: _____ Milk: _____ Water: _____

Do you smoke?
☐ Yes ☐ No If yes, how much and for how long? _____

Do you drink alcohol?
☐ Yes ☐ No If yes, how much and for how long? _____

How often do you have bowel movements? _____

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

_____

_____

Do you have specific concerns? _____

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

Client Signature: _____ Date: _____ / _____ / _____
Client Printed (Full Name): _____