Client Information / Pre-Session Interview

Name: _____ Today's Date: _____
Address: _____
City: _____ Prov./State: _____ Postal/Zip Code _____
Phone (Day): _____ Phone (Eve.): _____ E-Mail Address: _____
Age: _____ Occupation: _____
Have you had colonics before? _____ How Many? _____ When? _____
Other Cleansing experiences include: _____
_____
Name of your M.D., Herbalist and/or N.D.? _____
What are your reasons for having colonics? _____

DIET AND LIFESTYLE

On a scale of 1 to 10, what is your stress level? _____ Your Blood Type: _____
Vegetarian? _____ for how many years? _____ eggs and dairy? _____ or vegan? _____ Raw foods % in Diet? _____
Frequency of Consumption? Poultry/Fish: _____ Red Meat: _____ Dairy: _____
Eggs: _____ Flour Products/Bread: _____ Caffeine: _____ Sugar: _____
Salt: _____ Artificial Sweeteners: _____ Cola/Pop: _____ Drink alcohol? _____
Do you buy organically grown foods? _____ Smoke? _____
Take Medical Drugs? (please list) _____
Take Herbal and/or nutritional supplements? (please list) _____
What is your water intake per day? (in cups) _____

HEALTH CONDITIONS

Any problems with: Constipation, Diarrhea, Abdominal pain, Hemorrhoids, Gas? (please circle.)
How often do you have a bowel movement? _____
Any other colon problems? now: _____ or in the past: _____
Have you taken antibiotics in the past? _____ Chemical laxatives? _____ Birth Control? _____
Food allergies or food restrictions: _____
Diagnosed health conditions: _____
Do you have, or are a carrier, of an infectious disease? _____ If so what? _____
Bleeding disorder? Heart condition?

<u>Contraindications:</u> Do you presently have, or have you had any of the following conditions? If in the past how long ago? Please circle yes or no:

Cancer of the Colon or GI tract	YES / NO	Vascular aneurysm	YES / NO
Acute abdominal pain	YES / NO	Renal insufficiency	YES / NO
Recent history of GI bleeding	YES / NO	Epilepsy or psychoses	YES / NO
Congestive heart failure	YES / NO	Cirrhosis	YES / NO
Uncontrolled hypertension	YES / NO	Carcinoma of the rectum	YES / NO
History of Seizures	YES / NO	Severe hemorrhoids	YES / NO
Abdominal surgery	YES / NO	Intestinal perforation	YES / NO
Diverticulitis	YES / NO	Fissures or fistula	YES / NO
Recent heart attack	YES / NO	Abdominal hernia	YES / NO
General debilitation	YES / NO	Pregnancies in past	YES/ NO how many?
Recent colon or rectal surgery?	YES / NO	Pregnant now?	YES/ NO

How did you hear about our office?:

*Doctor's Referral: name _____ *Health Care Practitioner: name _____
*Phone Book: _____ *Magazine _____ *Friend: _____
*Card/Flyer: _____ *Internet _____ *Other _____

All information will be held in strict confidence. This information may help your therapist to assist you better in your quest for optimal colon hydrotherapy results. It is not intended to diagnose or prescribe and is not a replacement for your regular medical attention by your Physician. I have read the contra indications for colonic irrigation listed above and with my signature below I testify that I DO NOT HAVE ANY of the listed conditions.

Please print your name: _____
Signature: _____ **Date:** _____
Address: _____ **Telephone:** _____

Please Note: This is a sample Client Information / Pre-Treatment Interview form only. Before using this form or any part of it, check for compliance with your local regulatory authorities and amend as necessary to be in compliance.