Client History
Colon Therapy

This information will help us meet your individual needs. Thank you for your cooperation.

Name	Date
Address	City, State, Zip
Phone: Home	Phone: Business
Phone: Cell	Email Address
Occupation	Birth Date
Height	Weight
Marital Status	Male/Female
Referred By	How did you find out about us?

Please describe your primary complaint:_____
_____

Describe any special problems:_____
_____
_____

IT IS IMPORTANT to have a thorough understanding of your past and present physical condition to provide you with a quality health care program. Take your time and check any of the following you **HAVE** had **or CURRENTLY HAVE.**

GASTROINTESTINAL
- ❑ recent constipation
- ❑ chronic constipation
- ❑ diarrhea
- ❑ intestinal worms
- ❑ colitis
- ❑ diverticulitis.
- ❑ bowel impactions
- ❑ hemorrhoids
- ❑ appendicitis
- ❑ bloody or black stools
- ❑ fistula or fissures
- ❑ ulcers
- ❑ hernia
- ❑ Crohn's Disease
- ❑ recurrent abdominal pain
- ❑ vomiting
- ❑ persistent change in stool
- ❑ protruding, sagging, tender stomach
- ❑ gas, belching or flatulence

METABOLIC
- ❑ underweight
- ❑ overweight
- ❑ diabetes
- ❑ low blood sugar
- ❑ high cholesterol
- ❑ frequent heart burn
- ❑ obesity

MUSCULOSKELETAL
- ❑ painful joints
- ❑ leg or muscle cramps
- ❑ muscle pains
- ❑ recent accident

CONTAGIOUS DISEASE
- ❑ Epstein Barr Virus
- ❑ HIV
- ❑ Mononucleosis
- ❑ Hepatitis
- ❑ Herpes

GENERAL
- ❑ heart disease
- ❑ cancer
- ❑ skin sores
- ❑ body odors
- ❑ high blood pressure
- ❑ low blood pressure
- ❑ frequent headaches
- ❑ migraine headaches
- ❑ nervousness, anxiety
- ❑ insomnia
- ❑ irritability
- ❑ anemia
- ❑ arthritis
- ❑ menstrual problem
- ❑ prostate trouble
- ❑ fatigue

Are you on a nutritional diet program? _____ yes _____no
Are you taking vitamins and minerals? _____ yes _____no

Please list the supplements you are taking.

1_____ 7_____
2_____ 8_____
3_____ 9_____
4_____ 10_____
5_____ 11_____
6_____ 12_____

Have you had a:

1. Barium Enema _____ yes _____ no _____ year
2. Blood Test _____ yes _____ no _____ year
3. Hair Analysis _____ yes _____ no _____ year
4. Urine Analysis _____ yes _____ no _____ year
5. Colon Scope _____ yes _____ no _____ year

Please List:

1. Surgeries Date

_____
_____
_____

2. Medications you are currently taking:

_____
_____
_____

3. Allergies:

_____
_____
_____

Habits	How Much?		How Much?		How Often?
Coffee	_____	Alcohol	_____	Exercise	_____
Tea	_____	Drugs - Medication	_____	Rest	_____
Soda Pop	_____	Recreation	_____	Mediation	_____
Tobacco	_____	Anxiety	_____	Stress Release	_____
Sugar	_____	Dieting	_____		

Frequency of bowel movements:
___Less than once a week
___Once a week
___About every ___days
___Daily
___Twice Daily
___Other, describe_____
_____

Occurance of bowel movements:
___Spontaneous
___Only after eating something
___Effortless
___Often requires straining
___Painful
___Blood in stool

Use of laxative:
___Frequent
___Occasional
___Never
Type of laxative used:
_____
___Enema

Colon Health:

Is this your first Colon Hydrotherapy session? _____ Yes _____ No
If not, where and when was your most recent visit?

_____

What, if any, is your prior experience with colon cleansing, other than hydrotherapy?

___fasting ___juicing ___herbs ___Health spa ___other_____

Are you currently fasting? _____Yes _____No Are you currently cleansing?_____Yes _____No

If yes, type of fast or cleanse program

_____

My intention for hydrotherapy is

_____

Which of the following apply to you? Use "C" for Currently, "P" for Past.

____ Abdominal Gas	____ Crohn's	____ Irritable Bowel Syndrome
____ Anal discomfort/itching	____ Diverticulitis / osis	____ Lactose intolerance
____ Anal / rectal bleeding	____ Diarrhea	____ Nausea
____ Appendicitis	____ Fatigue after eating	____ Parasites
____ Atonic colon	____ Fissure	____ Polyps
____ Bad breath	____ Fistula	____ Poor appetite
____ Belching / bloating	____ Gallstones	____ Rectal / GI hemorraghing
____ Carcinoma	____ Gastroparesis	____ Redundant / prolapsed colon
____ Celiac disease	____ Hemorrhoids	____ Reflex / heartburn
____ Colitis	____ Hernia	____ Spastic colon
____ Constipation	____ Hungry all the time	____ Vomiting
____ Cramping	____ Indigestion	____ Worms in stool

Please list any intestinal-related procedures you have had, along with the year it took place:

___barium enema ___colonoscopy ___sigmoidoscopy ___surgery ___other_____

Bowel Health:

How many bowel movements do you usually have?
Per day _____ # Per week _____

Do you strain to have a movement? Yes _____ No _____
Does the movement feel complete? Yes _____ No _____

Please check applicable responses. The stool . . .

____ Shows signs of mucus
____ Shows signs of blood
____ Has a strong odor

General Health:

Blood Type_____ Have you been hospitalized within the past year?_____ In the past 5 years?_____

If yes, why?_____

Which of the following apply to you? Use "C" for Currently, "P" for Past.

____ Allergies
____ Anemia
____ Anorexia
____ Anxiety
____ Appendicitis
____ Arthritis
____ Asthma
____ Auto immune disorder
____ Bloodclot / vessel disorder
____ Binging / bulimia
____ Cancer
____ Candida albicans
____ Chemical toxicity
____ Cholesterol high / low
____ Chronic fatigue
____ Convulsions
____ Currently ___ months pregnant
____ Depression
____ Diabetes
____ Dizziness
____ Eating disorders
____ Edema
____ Environmental sensitivities
____ Epstein-Barr
____ Extreme weight gain / loss
____ Fainting
____ Fatigue
____ Fever / chills
____ Fibro / polymialgia
____ Headaches / migraines
____ Heart condition
____ Heart didease
____ High / low blood pressure
____ Irregular menstrual cycle
____ Kidney stones
____ Liver disease
____ Loss of sleep
____ Low blood sugar
____ Low libido
____ Lung disorder
____ Lupus
____ Lyme disease
____ Metal poisoning
____ Menopause
____ Mental disorder
____ Nerve disorder
____ PMS
____ Prostate condition
____ Renal insufficiency
____ Sinus condition
____ Skin condition
____ Spleen / pancreas problems
____ Sweats
____ Thyroid problems
____ Toxicity
____ Tumor
____ Ulcer
____ Urinary tract infection

Have you been recently diagnosed with a major illness?

_____

Have you recently had chemotherapy or radiation?

_____

Do you use any of the following? How frequently?

___ antibiotics

_____

___ over-the-counter drugs

_____

___ pacemaker How long?

_____

___ prescribed birth control

_____

___ recreational drugs

_____

___ steroids

_____

___ supplements (please list)

_____

_____

_____

___ prescription drugs (please list)

_____

_____

_____

___ antidepressants (please list)

_____

_____

_____

_____

Diet:

Using the following key, please indicate your dietary usage.
H = Heavy (5 - 7 times a week); M = Moderate (2 - 4 times a week);
L = Light (once a week or less); N = Never (Really, never!)

____ Alcohol	____ Chocolate	____ Ice cream	____ Salt
____ Algae	____ Dairy	____ Junk food	____ Smoothies
____ Antacids	____ Decaf coffee / tea	____ Nuts / seeds	____ Soda
____ Aspirin	____ Desserts	____ Organic foods	____ Soy
____ Baked goods	____ Eggs	____ Pasta	____ Sugar
____ Beans	____ Fatty foods	____ Poultry	____ Tobacco / cigarettes
____ Bread	____ Fish	____ Popcorn	____ Vegetables
____ Caffeinated coffee	____ Flax fiber	____ Processed foods	____ Water
____ Caffeinated tea	____ Fried foods	____ Protein shakes	____ Wheat / flour products
____ Carbonated water	____ Fruit	____ Psyllium fiber	____ White bread
____ Cheese	____ Gum	____ Red meat	____ Whole Grains
			____ Yogurt

Briefly describe your typical dietary intake for the following meals:

Breakfast

_____

Lunch

_____

Dinner

_____

Snacks / desserts

_____

Do you have any food cravings? ___ No ___ Yes___

Lifestyle:

Are you currently under any excessive or unusual mental of physical stress? Please describe briefly:

_____

How do you relax?

_____

Do you exercise? ___Yes ___ No

If yes, how do you exercise?

_____

Do you practice any forms of: ___Meditation ___Prayer ___12-step program
___Other_____

Are you, or have you been, addicted to:

__Alcohol __Coffee __Sugar __Drugs __Prescription drugs __Other

_____

If there are other areas of your lifestyle or your life history (such as post-traumatic stress or sexual abuse) that you feel would be appropriate for us to know in order to better meet your needs, please comment in the space below. All information is strictly confidential.

_____

Client Signature:_____ Date:_____

Informed Consent Form

I, the undersigned, authorize the therapist to administer Colon Hydrotherapy sessions. These therapist are not physicians and therefore are not qualified to diagnose or prescribe. I understand how Colon Hydrotherapy is performed and used, and I acknowledge the potential benefits and risks of Colon Hydrotherapy as described below:

COLON HYDROTHERAPY (or a colonic) is a gentle purified water washing of the large intestine. The client lies on a massage table and, with a Colon Hydrotherapy instrument, water is run very slowly into the colon by the practitioner. When slight pressure builds up in the colon, the practitioner reverses the water flow to empty. As the water and waste are flowing out through an illuminated glass viewing tube, the abdominal area is massaged. This process is repeated several times during the period for 45 – 50 minutes. **The Colon Hydrotherapist is always present in the room with the client during each session.**

COLON HYDROTHERAPY may be used to cleanse the colon by removing fecal material, gas, and mucus. It may also be prescribed by a physician in preparation for the diagnostic study of the large intestine or for other conditions.

Possible contraindications are: severe cardiac disease, GI hemorrhage/perforation, carcinoma of the colon, recent colon surgery (within 6 months), and renal insufficiency. **If you have any of these conditions you must consult your physician first.** Frederick or Claudine Young **will review your questionnaire at the first visit before you receive Colon Hydrotherapy to determine whether or not this procedure is appropriate for you.**

- **I affirm that I understand the purpose and potential benefits of Colon Hydrotherapy.**
- **I understand and freely accept the potential risks of the procedure.**
- **An offer has been made to answer my questions about the procedure.**
- **I freely and voluntarily consent to the above procedure.**
- **I realize that no guarantee as to the results that may be obtained has been given to me by the practitioner.**
- **I hereby release Frederick and Claudine Young and Complete Colon Care from any and all liability which may occur in connection with the above mentioned procedure.**
- **I understand that I am free to withdraw my consent and to discontinue participation in this procedure at any time.**
- **I am not acting as an agent for any government agency, law office, or pharmaceutical company.**

Signature of Patient (or of Guardian if under age 18):

_____ DATE _____

Financial Policies

Colon Hydrotherapy:

Initial Session	$75.00
Subsequent Visits	$65.00

Payment for services is expected in full at the time they are rendered.

- Our cancellation fee is the full amount of the missed appointment if NOT cancelled one business day (24 hours at least) prior to appointment date. Appointments are considered confirmed when they are scheduled.
- It is our policy that all clients keep their accounts current.
- Any accounts over thirty days will accrue interest at the rate of 1.5% per month. Accounts delinquent over 90 days are due in full and will be referred to collection. All collection costs and legal fees will be added to the account.
- I understand and agree that I am responsible for the balance on this account for services including Colon Hydrotherapy fees, supplements, and any fees charged to me for missed or late cancellations of appointments.
- Insurance does not cover the cost of Colon Hydrotherapy.
- Clients may request a superbill which includes all necessary codes to submit to their insurance company for possible reimbursement for these services.
- I have read and understand the above financial information regarding fees and financial policies of this office, and agree to abide by them.

Signature of Patient (or of Guardian if under age 18):

_____

Date_____