



COLON HYDROTHERAPY INTAKE FORM

(All information is kept strictly confidential)

NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: ____/____/____ AGE: _____ HEIGHT: _____ WEIGHT: _____

HOME ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE _____

PREFERRED CONTACT PHONE NUMBER: _____

EMAIL ADDRESS: _____

OCCUPATION: _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT NUMBER: _____

How did you hear about Renewed Health & Wellness? Online ___ Referral ___ Social Media ___ Other ___

What is your Primary Health Concern? _____

Physician's Name? _____ Phone Number _____

Have you ever had a colonic before? (Circle One) YES NO

If yes, how many sessions have you had? _____ How many per year? _____

Why have you chosen Colon Hydrotherapy? _____

List any other types of Cleansing Experiences: _____

For Women: Date of last menstrual cycle? _____ Are you pregnant? Yes ___ No ___

List any digestive or intestinal issues that you think you have or have been diagnosed with: _____

Do you have or are you a carrier of an infectious disease? (Circle One) YES NO

Do you have C-Diff _____ Sibo _____

Do you have a family history of digestive problems and/or colon cancer? (Circle One) YES NO

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ALL ABOUT POOP

How often do you have a bowel movement? _____ At what time of day? _____

Are they: (Circle those that apply) Spontaneous After Eating Requires Straining Effortless

Are your bowel movements: (Circle any that apply) Explosive Strained Easy Various Other

If Other, please explain: _____

What is the typical consistency of your Stool? (Circle any that apply)

Formed Unformed Hard Runny Various

What is the typical size of your Stool? (Circle any that apply) Small Medium Large Pebbly

Pencil Thin Flat Various Other, please explain: _____

When you Eliminate what would you say you feel? (Circle any that apply) Complete

Incomplete Various Other please explain: _____

What is the usual colour of your stool?

What would you say the transit time (the time it takes for a meal to pass through the digestive tract) is for you? (Circle any that apply)

< 12 hours 12-24 hours 24-36 hours 2 days 3 days No Clue

Do you use Laxatives? YES NO

If yes, do you use: Over the counter laxative? _____ Herbal laxative? _____

Stool softener? _____ Suppository? _____ Enema? _____

Do you have hemorrhoids? YES NO SOMETIMES NOT SURE

Have you had any Rectal bleeding? YES NO SOMETIMES If Yes, please explain _____

Have you ever had a: (Circle any that apply) BARIUM ENEMA COLONOSCOPY COLON

SURGERY RECTAL SURGERY APPENDECTOMY (Removal of the Appendix)

GALLBLADDER SURGERY

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DIET AND LIFESTYLE

On a scale of 1 to 10, What would you say your stress level is? _____

Do you exercise regularly? YES NO If Yes: How many days a week do you exercise? _____

How long on average? _____ What types of exercise you enjoy? _____ - _____

How many glasses or ounces of water do you drink daily? _____

Circle that which typically describes your diet:

Raw foods Dairy Meat Vegan Vegetarian Fast Food Fried Foods

Processed Whole Foods

Circle the type of foods that you eat on a daily basis:

Starchy vegetables Green Vegetables Beans/Legumes Fruit Rice White Flour

Whole Grains Beef Pork Fish Eggs Chicken Seeds Nuts Butter

Vegetable Oils Dairy Pasta Sweets

Do you still feel hungry after eating what you would consider a decent-size meal? YES NO SOMETIMES



RENEWED HEALTH & WELLNESS DISCLAIMER

Terms of Treatment: I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder and does not prescribe medical treatment or pharmaceuticals. It has been made clear to me that colon hydrotherapy is not a cure or substitute for medical examination or diagnosis and that it is recommended that I see a physician for any ailments that I might have. I acknowledge that I have fully and honestly disclosed my health history to the therapist. I agree that the therapist is helping me with natural hygiene at my request, and is not diagnosing a disease. I give my permission for the Colon Hydrotherapist to assist me with the insertion of the colonic speculum into my rectum and administer the colonic.

Client Signature

Date

A Contraindication is any symptom that makes it inadvisable to use a particular therapy. The following are contraindications for Colon Hydrotherapy. If any of these apply to you, we are not able to treat you with Colon Hydrotherapy at the present time.

If you have any of these contraindications you may still be eligible to receive Colon Hydrotherapy once they have subsided or been eliminated or if you are under the guidance and supervision of a qualified physician.

- | | | |
|--|--------------------------------|-----------------------|
| Cancer of the Colon or GI tract | Ulcerative Colitis | Diverticulitis |
| Acute Abdominal Pain | Acute Crohn’s Disease | General Debilitation |
| Recent history of GI or Rectal bleeding | Rectal Tumors | Recent Heart Attack |
| Congestive Heart Failure | C-Diff (Clostridium Difficile) | Vascular Aneurysm |
| Uncontrolled Hypertension (Blood Pressure) | Pregnancy | Cirrhosis |
| History of Seizures | Recent Colon or Rectal Surgery | Renal Insufficiency |
| Carcinoma of the Rectum | Fissures or Fistula | Abdominal Hernia |
| Abdominal Surgery | Severe Hemorrhoids | Epilepsy or Psychosis |
| Intestinal Perforation | | |

WAIVER AND RELEASE OF LIABILITY:

I, the undersigned, consent to having a Colonic. I understand that this service is not intended to take the place of medical care or medications. I confirm that I do not have any contraindications for the Colon Hydrotherapy session. I understand that I take full responsibility for my own health and well-being. I agree to disclose to “Renewed Health & Wellness Inc.”, if my medical health history should happen to change.

I have read the above statements (including cautions and contraindications for the Colon Hydrotherapy session) and I agree that I am not currently suffering with any of the above mentioned contraindications. By signing below I agree to release Renewed Health & Wellness Inc. and its members from any liability in connection with the Colon Hydrotherapy session. We do not release your information to any third party.

Client Name: _____
(Please print)
Client Signature: _____ **Date:** _____

