

COLON HYDROTHERAPY INTAKE FORM

NAME _____	BIRTH DATE _____	DATE _____
ADDRESS _____	CITY _____	ST _____ ZIP _____
HOME PHONE _____	WORK PHONE _____	EMAIL _____
OCCUPATION _____	REFERRED BY: _____	

SEX _____ HT _____ WT _____ ARE YOU CURRENTLY PREGNANT? Y N MONTHS: _____

CHILDREN _____ MISCARRIAGES/ABORTIONS _____

DO YOU HAVE ANY ALLERGIES TO FRAGRANCES OR TOPICAL PREPARATIONS? _____

ARE YOU CURRENTLY UNDER MEDICAL TREATMENT? _____ FOR WHAT CONDITIONS? _____

PLEASE LIST YOUR DOCTOR'S NAME AND NUMBER: _____

DO YOU HAVE OR HAVE YOU EVER EXPERIENCED:

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> PSORIASIS
<input type="checkbox"/> ADRENAL FATIGUE	<input type="checkbox"/> DIVERTICULITIS	<input type="checkbox"/> RECTAL/ANAL BLEEDING
<input type="checkbox"/> ALLERGIES	<input type="checkbox"/> ECZEMA	<input type="checkbox"/> RECTAL/ANAL PAIN
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> FIBROIDS	<input type="checkbox"/> RESPIRATORY INFECTION
<input type="checkbox"/> ANXIETY	<input type="checkbox"/> FIBROMYALGIA	<input type="checkbox"/> SKIN CONDITIONS
<input type="checkbox"/> APPENDICITIS	<input type="checkbox"/> GALL BLADDER PAIN	<input type="checkbox"/> SURGERY
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> GALL STONES	<input type="checkbox"/> SYNCOPE (FAINTING)
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> GASTRITIS	<input type="checkbox"/> ULCER
<input type="checkbox"/> AUTOIMMUNE DISEASE	<input type="checkbox"/> HEADACHES	
<input type="checkbox"/> BACKACHE: UPPER MID LOWER	<input type="checkbox"/> HEMORRHOIDS	INTAKE: CURRENT OR PAST
<input type="checkbox"/> BAD BREATH	<input type="checkbox"/> HERNIA	<input type="checkbox"/> ALCOHOL
<input type="checkbox"/> BLOOD IN STOOL	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> ANTACIDS
<input type="checkbox"/> CANCER	<input type="checkbox"/> HYPER/HYPOTHYROID	<input type="checkbox"/> ANTIBIOTICS
<input type="checkbox"/> CANDIDIASIS	<input type="checkbox"/> INDIGESTION	<input type="checkbox"/> ASPIRIN/IBUPROFEN
<input type="checkbox"/> CARDIAC PROBLEMS	<input type="checkbox"/> IRRITABLE BOWEL (IBS)	<input type="checkbox"/> BLACK TEA
<input type="checkbox"/> CHEMICAL SENSITIVITIES	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> COFFEE: _____ CUPS/DAY
<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> LEAKY GUT SYNDROME	<input type="checkbox"/> DAIRY
<input type="checkbox"/> CHRONIC FATIGUE/CFIDS	<input type="checkbox"/> LIVER DISORDERS	<input type="checkbox"/> DRUGS (RX OR REC.)
<input type="checkbox"/> COLITIS	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> GREEN LEAFY VEGGIES
<input type="checkbox"/> COMPROMISED IMMUNITY	<input type="checkbox"/> MUCUS IN STOOL	<input type="checkbox"/> MEAT: WHITE RED
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> PARASITIC INFECTION	<input type="checkbox"/> SODA
<input type="checkbox"/> CROHN'S DISEASE	<input type="checkbox"/> PMS	<input type="checkbox"/> SUGAR
<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> POLYPS	<input type="checkbox"/> WATER: _____ CUPS/DAY
<input type="checkbox"/> DIABETES	<input type="checkbox"/> PROSTATE PROBLEMS	<input type="checkbox"/> WHEAT

PLEASE DESCRIBE IN FURTHER DETAIL ANYTHING CHECKED ABOVE:

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT? (INJURIES, ILLNESSES, ACCIDENTS, ETC.)

COLON HYDROTHERAPY INTAKE FORM (Cont'd)

HAVE YOU EVER RECEIVED A COLONIC BEFORE? _____ IF SO, WHEN? _____

RESULTS _____

DO YOU OR HAVE YOU EVER TAKEN LAXATIVES? Y N HOW OFTEN? _____

TYPE: _____ RESULTS _____

HAVE YOU EVER DONE AN HERBAL CLEANSE? Y N IF SO, WHICH ONE(S)? _____

RESULTS _____

HAVE YOU EVER FASTED? TYPE: JUICE LIQUID WATER OTHER _____

FOR HOW LONG? _____ RESULTS _____

BOWEL MOVEMENTS: #/DAY _____ OR #/WEEK _____	
COLOR (circle): DARK BROWN LIGHT BROWN YELLOW BLACK RED GREY OTHER _____	
ODOR: NONE SWEET SHARP PUTRID APPROX. LENGTH _____ DIAMETER _____	
TEXTURE: SOFT HARD SMOOTH FLAKY BRAIDED LOOSE 'RABBIT PELLETS'	
OTHER _____ DEFECATION IS: EASY HARD PAINFUL SHORT LONG RARE	
FOOD IN STOOL? Y N IF SO, WHAT FOODS? _____	

WHAT DOES YOUR DAILY DIET CONSIST OF? _____

CRAVINGS? Y N _____ DO YOU EAT LATE AT NIGHT? Y N

SLEEP: HRS/NIGHT _____ BEDTIME _____ DO YOU AWAKE FEELING RESTED? _____

EXERCISE: HOW OFTEN _____ WHAT TYPE(S) _____

BLOOD PRESSURE _____ PULSE RATE _____ CHOLESTEROL COUNT _____ BLOOD TYPE _____

DO YOU RECEIVE NATUROPATHIC CARE? Y N MASSAGE? Y N TYPE(S): _____

ACUPUNCTURE/ORIENTAL MEDICINE? Y N ORIENTAL DIAGNOSIS: _____

WHICH DO YOU EXPERIENCE MOST OFTEN: JOY SADNESS FEAR WORRY ANGER RAGE	
PAIN JEALOUSY SHAME GUILT DISDAIN APATHY OTHER _____	
WHAT WOULD YOU LIKE TO FEEL MOST OFTEN? _____	
WHAT ARE THE CURRENT STRESSORS IN YOUR LIFE? _____	
WHAT ACTIVITIES HELP TO RELIEVE STRESS FOR YOU? _____	

WHAT IS YOUR REASON FOR COMING HERE TODAY? _____

WHAT IS YOUR GOAL FOR THE SESSION? _____

*** * * CONTRAINDICATIONS * * ***

A contraindication is any indication or symptom that makes it inadvisable to use a particular therapy.

Absolute contraindications prohibit treatment altogether. For example, colon hydrotherapy is absolutely contraindicated for patients with pronounced rectal bleeding. Relative contraindications involve a risk/benefit ratio. In the case of colon cancer, colon hydrotherapy's ability to eliminate poisonous toxins is evaluated against possibly weakening the already-compromised colon walls.

The following are **absolute contraindications** for colon hydrotherapy. If you have any of these, colon hydrotherapy is **NOT** advised. Once they have subsided or been eliminated, colon therapy may be indicated.

- Abortion (less than 6 months)
- Anal Fissure/Fistula (a tear in the colon)
- Anemias (Severe)
- Aneurysm
- Cirrhosis
- Colon Cancer (see below)
- Colon Surgery (less than six months post-op: see below)
- Colostomy
- Crohn's disease (in the acute inflammatory or bleeding stages)
- Epilepsy
- GI Hemorrhage/Perforation
- Heart Disease(Severe, Uncontrolled Hypertension; Congestive Heart Failure)
- Hemorrhoids (severe or bleeding [minimal bleeding is okay])
- Hernia (abdominal/inguinal)
- History of seizures
- Kidney Dialysis
- Miscarriage (less than 6 months)
- Pregnancy (up to 4 months)
- Recent heart attack
- Rectal Bleeding (except for minor hemorrhoids)
- Renal Insufficiency
- Tumor in the Rectum or Large Intestine
- Ulcerative colitis (active or bleeding)

*The following are **relative contraindications** for colon hydrotherapy. A physician prescription is necessary. Eíreen is happy to provide referrals to MDs and NDs in the Portland area who will evaluate you and write you one.*

- Crohn's Disease
- Acute Colitis
- Severe Diverticulosis / Acute Diverticulitis
- Colon Cancer (need MD approval on integrity of colon)
- Colon Surgery (need MD approval on integrity of colon)

Please know that insurance does NOT generally cover colon therapy treatments.

CLIENT AGREEMENT

I understand that the therapist does not diagnose, treat or prescribe for any illness, ailment or disease and does not do any spinal manipulations. While the therapist may assist me in relief of physical or emotional symptoms, I understand that it is not the function of the therapist to try to cure me and that I am responsible for my own body, feelings and emotions. It is clear to me that colon hydrotherapy is not a substitute for medical examinations or diagnosis and that it is recommended that I see a physician for any physical ailment.

It is understood that colon hydrotherapy is a safe and therapeutic form of detoxification. The focus and intent of this work is wellness of body. Stress reduction and pain relief are just a few of the benefits of colon hydrotherapy.

Control of the session is mine. I will feel free to comment on the comfort or discomfort of the session at any time. I can say "Stop" at any time during the session.

I agree not to eat or drink two hours before the session and to be free of alcohol and recreational drugs. In consideration of people with allergies to fragrances, I agree to refrain from using scented products on the day of my treatment.

I understand that I will be fully covered with a sheet or blanket at all times when unclothed and only the part of my body being addressed will be uncovered.

I am aware that this is a non-sexual treatment. Any misconduct or inappropriate behavior in this area will result in the immediate termination of the session with full payment due.

If I am late for an appointment I understand my time may be shortened as a result. Twenty-four hours' notice is required for cancellation of an appointment by me or by the therapist. If the therapist fails to give me a 24-hour cancellation notice, the next session will be provided free of charge. If I fail to give 24 hours' notice or fail to keep an appointment, I will be responsible for the full cost of the session.

I agree to pay by check, cash or credit card before or after the session. If my check does not clear, I agree to pay a \$15 service fee, as well as any additional charges the therapist may incur as a result.

I, THE UNDERSIGNED, HEREBY ACKNOWLEDGE THAT ÉIREEN CULLEN, CCH, LMT HAS NOT, IS NOT, AND WILL NOT PRESCRIBE (ORDER FOR USE AS MEDICINE) FOR ME AT ANY TIME, AND I, THE UNDERSIGNED, WILL NOT HOLD HER ACCOUNTABLE FOR SUCH. THE THERAPIST IS HELPING ME WITH NATURAL HYGIENE AT MY REQUEST, AND IS NOT DIAGNOSING NOR TREATING DISEASE, NOR PRACTICING ANY FORM OF MEDICINE.

Date: _____

CLIENT'S SIGNATURE