

Mississauga Colonics
Confidential Intake Form

Date: _____ Referral source: _____
Name: _____ Date of birth: _____
Address: _____ City: _____ Postal code: _____
Phone: Home: _____ Cell: _____
E-mail : _____ Occupation: _____

What symptoms or health concern brings you to this appointment? _____

Please list any disease, illness or ailments you have been diagnosed with: _____

Have you been hospitalized, or had surgery, or any organ(s) removed? _____

Contraindications for colon hydrotherapy and other digestive disorders please mark with a Y or N:

IBS _____ Colitis _____ Crohn's _____ Ulcer _____ Diverticulitis _____ Diabetes _____ Polyps _____ Gallstones _____

Appendicitis _____ Kidney Stones _____ **Anal Fissure** _____ **Colon Cancer** _____ **Surgery** _____ **Hernia** _____

Renal Failure _____ **Liver cirrhosis** _____ **Hemorrhoids** _____ **Heart Failure** _____ **Are you pregnant?** _____

Intestinal perforation _____

List any medication you are currently taking (prescription and over the counter) along with the reason why you are taking it.

Do you take any of the following supplements? How often? Probiotic _____x/day, Magnesium _____x/day, Digestive enzymes _____x/day, Fiber _____ tsp/tbsp x/day, Vit. C _____x/day, Multivitamin _____x/day, Protein _____ (grams/day)

Emotions: What is your current level of stress? Minimal _____ Average _____ Considerable _____

Are there any stressful circumstances in your life right now? _____

How many hours of sleep do you get/night? _____ Do you wake feeling rested? _____

Do you experience (Y or N): Mood Swings? _____ Depression? _____ Anxiety? _____ PMS? _____

How often do you eat the following in a week? Red Meat _____ Poultry _____ Fish _____ Nuts _____ Fruit _____

Vegetables (raw) _____ (cooked) _____ Dairy _____ Baked Goods _____ Whole Grains _____ Chocolate _____ Fast Food _____

White Flour products (rice, bread, pasta etc.) _____ Natural juicing _____ Alcohol _____ Coffee _____ Pop _____ Cigarettes _____

How many glasses of water do you drink daily? _____ Do you eat breakfast daily? _____

List any food allergies? _____

What foods do you crave? _____

Are you on a cleanse or special diet? _____ Are you a vegetarian/vegan? _____ For how long? _____

Do you exercise? _____ Weights/cardio? _____ Are you interested in weight loss? _____

Chemicals (Yes or No)

Were you a smoker? _____ If you quit, when? _____ Do you take antibiotics at least once/year? _____

Drink tap water? _____ Eat organic fruit and vegetables? _____ Have you travelled in the last year? _____

Do you experience the following digestive difficulties (please check all those that apply):

Bloating _____, Constipation _____, Heartburn_____, Gas _____, Burping _____, Diarrhea _____,
Abdominal pain _____, Fatigue _____, Headaches _____, Joint Pain _____
Do you use laxatives? _____ What kind and how often? _____ Do you use antacids? _____

Stool Indicators (Yes/No)

The following are helpful indicators of the health of your bowels as well as your overall health. Under each heading please circle all responses that apply in an average week. If you have been experiencing diarrhea please indicate this.

How many bowel movements per week (#)? _____ Do you have to push or strain? _____ Do you have pain? _____
Do you take fiber supplements? _____ Are your bowel movements large (6-8") and solid? _____
Do you experience frequent bouts of diarrhea? _____ Is there a history of cancer in your family? _____

I, the undersigned, acknowledge that the personnel at Mississauga Colonics are not prescribing (ordering for use as medicine) for me at any time, and I will not hold them accountable for such. Any recommendations I receive are not intended as primary therapy for any symptom or disease, but as a means of enhancing the quality of my diet. I understand that Colon Hydrotherapy is a professional service which may provide information related to nutritional requirements; however this service is not a tool for the prevention, assessment, diagnosis, or treatment of any particular illness or disease. The services I receive are initiated at my own request for reasons personal to me. I understand that all sessions and series I purchase are non-refundable but can be transferred to a friend at anytime. I am responsible to be at my scheduled appointment on time. **If I miss or cancel my appointment without giving 24 hours notice by phone I agree to be charged a \$50 late cancellation fee to Mississauga Colonics or have the equivalent deducted from my current series of colonics on file.**

Client signature _____ **Date** _____

Client Progress Sheet (Therapist Use Only)
