Chicago Internal Cleansing

Colonic Intake Form

TODAY'S DATE _____ Gender: _____Female _____Male

First Name: _____ Last Name: _____

Address: _____ City:_____ State:_____ Zip:_____

- PLEASE INDICATE BY CIRCLING BELOW THE BEST NUMBER TO CONTACT YOU.

Home Phone:_____ Work Phone:_____ Cell Phones:_____

Email: _____ Occupation:_____ Date Of Birth:_____

Marital Status: _____ Number of Children_____

Emergency Contact Name: _____ Contact Number: _____

How Did You Hear About Our Services? _____

Are you presently under a physician's care? Yes _____ No ____ If yes, for what condition?_____

_____

Doctor's Name: _____ Contact Number: _____

Have you Ever Had A Colonic? _____ Yes _____ No If so, When? _____ Where?_____

Do You Have A Latex Allergy? _____ Yes _____ No

A contraindication is any indication or 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 order, guidance and supervision of a qualified physician working with Chicago Internal Cleansing.

1. Cancer of the Colon or GI (gastro intestinal) Tract
2. Acute Abdominal Pain
3. Recent History of GI or Rectal Bleeding
4. Congestive Heart Failure
5. Uncontrolled Hypertension
6. History of Seizures
7. Carcinoma of the Rectum
8. Abdominal Surgery
9. Intestinal Perforation
10. Abdominal Hernia
11. Recent Colon or Rectal Surgery
12. Diverticulitis
13. Recent Heart Attack
14. General Debilitation

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15. Vascular Aneurysm
16. Renal Insufficiency
17. Epilepsy or Psychoses
18. Severe Hemorrhoids
19. Cirrhosis
20. Fissures or Fistula
21. Pregnancy
22. Ulcerative Colitis
23. Acute Crohn's Disease
24. Rectal or Abdominal Tumors

Please place your initials to confirm that you have read and understand all of the contraindications for Colon Hydrotherapy. Since the therapist is not licensed to diagnose disease states, I, the client take full responsibility for the status of my health and choose of my own free will to go ahead and have a colonic session performed. I, the client, also agree to let the therapist know of any changes to my health status with regard to future bookings:

_____ (initials please)

*** It is advisable if you are not aware of the status of your health at this time to seek out the services of a competent physician prior to booking a colon hydrotherapy session.**

List Any Other Types of Cleansing Experiences: _____

_____

List any Medications You Are Taking: _____

_____

List Any Supplements You are Taking: _____

_____

List Any Allergies You Have: _____

_____

List any Serious Illnesses/Hospitalizations/Injuries: _____

_____

What is Your Chief Health Concern? _____

I Usually Have a Bowel Movement, how often? _____Daily _____ Every 2 to 3 days _____ Every 3 to 5 days

How many Bowel Movements per day (on average) do you have? _____

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On The Following Questions Check All That Apply:

What is the consistency of your Stool? ____Formed ____Unformed ____Hard ____Runny ____Other

What is the size of your stool? ____Small ____Medium ____Large ____Pencil Thin or Flat ____Pebbly

____Other Explain:_____

When you eliminate, what would you say you feel? ___Complete ___Incomplete ___Explosive ___Strained

____Other

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

___12 hours ___24 hours ___2 days ___3 days ___Don't Know. What is the usual color of your stool? _____

Do you use laxatives? ____Yes ____No If yes, what types? _____

Do you have hemorrhoids? ____Yes ____No. Have you had any rectal bleeding? ____Yes ____No

If yes, please explain _____

Have you ever had any of the following: ____Barium Enema ____Colonoscopy ____Colon Surgery

____Rectal Surgery ____Appendectomy (removal of the Appendix) ____Gallbladder Surgery

For Woman:

Are your menstrual cycles regular? ___Yes ____No. Do you presently use birth control? ____Yes ____No

Have you ever used birth control? ___Yes___No. How long? _____. Have you ever had tubal ligation?

____Yes ____ No. Have you had a hysterectomy? ____ Yes ____No.

Are you now, or any possibility of being pregnant? ___Yes ___No. Are you trying to conceive? ____Yes ____No

Are you currently breastfeeding? ____Yes ____No

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For Everyone:

How many glasses or ounces of water do you drink daily? _____. What other liquids do you drink? Please, **check all that apply.**

___Juice___Soda ___Coffee ___Herbal Teas ___Black Tea ___Alcohol ___Protein Drinks ___Energy Drinks

___Other. If other, explain_____

Check all that apply to your diet: ___Raw Foods ___Whole Foods ___Eggs/Dairy ___Meat ___Vegan

___Vegetarian ___Standard American Diet ___Fast Food ___Fried Foods ___Artificial Sweeteners

Do you eat any dairy products? ___Yes ___No. If yes, what products?_____

If you had a so called cheat day, what foods would you crave?_____

Do you often get tired after eating? ____Yes ____No

Do you shake, get light headed or anxious when you miss a meal? ____Yes ____No

Current weight: _____lbs. Weight six months ago: _____lbs. One year ago: _____lbs

Would you like your weight to be different? ____Yes ____No. If yes, what weight? _____lbs

Do you sleep well? ____Yes ____No. What time do you generally get up for the day?_____ am _____pm

On average, what meals do you generally eat? ____Breakfast ____Lunch ____Dinner ____Snacks

Check The Foods That You Eat On A Daily Basis:

__Starchy Vegetables __Green Vegetables __Beans/Legumes __Fruit __Rice __White Flour __Whole Grains

__Meat __Fish __Eggs __Fowl __Seeds __Nuts __Butter __Vegetable Oils

Are you allergic to any foods? ____Yes ____No. What percentage is your food home cooked? _____%

How many times do you eat out during a week? _____. Do you smoke? ____Yes ____No

Do you exercise regularly?____Yes ____No. How many times a week do you exercise? ____

When did you last have a physical from your doctor? _____. Is your blood pressure under control? __Yes __No

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Rate on a scale (1 – 10) the stress in your life _____. Describe:_____

_____

Please check any of the current supplements you are taking: ___Fiber ___Acidophilus (friendly bacteria)

___Digestive Enzymes ___Essential Fatty Acids (Omega-3, 6, 9).

Please Check Any of These Conditions If They Apply To Your Health Status, Currently Or In The Past:

_____Constipation	____Diarrhea	____Spastic Colon
____Irritable Bowel Syndrome (IBS)	____Intestinal Gas (Bloating)	____Headaches
____Indigestion (Heart Burn/Acid Reflux)	____Heavy Mucus Production	____Skin Disorders
____Bad Breath	____Arthritis	____Parasites
____Brain Fog (Loss of Concentration)	____Fatigue	____Depression
____Kidney / Bladder Infection	____Backaches	____Weight Issues
____Candidiasis (Yeast Overgrowth)	____Sinus or Lung Conditions	____HIV Positive

What would you like to receive from this appointment for Colon Hydrotherapy?_____

_____

Please list any other comments or questions you might have here._____

_____

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, nor treating a disease, nor practicing any form of medicine.

If I cancel, reschedule, or skip an appointment without 24 hours notice, I agree to pay for the full session fee. I realize that the time scheduled was reserved specifically for me and I will respect the therapists time.

By placing my initials, I confirm my agreement to the "Terms of Treatment": _____ (initials)

All of the information provided above is, to my knowledge, correct and current.

Signed _____ Date: _____

Thank you for choosing Chicago Internal Cleansing for your detoxification and health maintenance needs.