COLON HYDROTHERAPY INTAKE FORM

PLEASE FILL OUT COMPLETELY

Name: ____ Date: ________________________

Address: ____

Telephone: (H) _________________ (W) __________________

Date of Birth: (DD) _______ (MM) _______ (YYYY) ___________ Age: _________ Sex: _________

Occupation: _______________________________

Name and Phone of spouse or closest relation to you: _______________________________________

Number of household members presently living with you: _________________________

List in order of importance the problems for which you are seeking treatment. Please circle the number of times per week you experience the problem.

Problem	# of times per week	Severity
1. ____________________________	1 or less,2,3,4,5,6,7,10,20,30,40,50	________________________
2. ____________________________	1 or less,2,3,4,5,6,7,10,20,30,40,50	________________________
3. ____________________________	1 or less,2,3,4,5,6,7,10,20,30,40,50	________________________
4. ____________________________	1 or less,2,3,4,5,6,7,10,20,30,40,50	________________________

Please rate the severity of the above problem(s) according to the scale below, and enter this number on the line which is above to your right.

1. MILD	the problem is just noticeable
2. MODERATE	the problem is annoying
3. SEVERE	the problem interferes with daily life
4. EXTREME	the problem is dehabilitating

How long have you had the problem(s)? 1. __________ 2. __________ 3. __________ 4. __________

Please give the name and address of family physician: ______________________________________

____

List the professionals you have seen for the problems and give approximate dates:

Name: _______________________________________ Telephone: ___________________________

Form of Treatment: _____________________________ Dates: _______________________________

Form of Treatment: _____________________________ Dates: _______________________________

TREATMENT INDEX

Current reasons for seeking treatment, please number in order of priority:

- __ Don't know
- __ Directed by someone else
- __ Allergies
- __ Amenorrhea
- __ Angina (pseudo)
- __ Arthritis
- __ Asthma
- __ Athletes foot
- __ Athletic injuries
- __ Back pain
- __ Bladder infections
- __ Boils
- __ Breast problems
- __ Bronchitis
- __ Bursitis
- __ Cancer
- __ Carpal Tunnel Syndrome
- __ Celiac Disease
- __ Crohn's Disease
- __ Colitis
- __ Constipation
- __ Cough
- __ Cramps
- __ Depression
- __ Diabetes
- __ Diarrhea
- __ Diverticulosis
- __ Dysemorrhea
- __ Edema (Swelling)
- __ Fibrositis
- __ Fissure
- __ Gout
- __ Headaches
- __ Heart Problems
- __ Heartburn
- __ Hemorrhoids
- __ Hepatitis: type ______
- __ Hernias
- __ Hypertension
- __ Hypoglycemia
- __ Insomnia
- __ Joints, stiffness
- __ Liver disease
- __ Loss of sexual drive
- __ Low back pain
- __ Multiple Sclerosis
- __ Muscular dystrophy
- __ Muscle spasms
- __ Myofacial Syndrome
- __ Neck
- __ Operations (recent)
- __ Osteoarthritis
- __ Parkinson's Disease
- __ Parasites
- __ Peptic Ulcers
- __ Peyers Patches
- __ Polyps
- __ Postural defects
- __ Prolapsed rectum
- __ Prostate
- __ Psoriasis
- __ Pulmonary Emphysema
- __ Raynaud's Disease
- __ Rheumatoid Arthritis
- __ Sciatica
- __ Scoliosis
- __ Sinusitis
- __ Spastic Colon
- __ Sprains
- __ Stress
- __ Swelling
- __ Tendonitis
- __ Tension
- __ Ulcer
- __ Vaginitis
- __ Warts

Please check items that you experience at least once or twice per week (continues on next page):

- ☐ Faintness/Dizziness
- ☐ Hot flashes
- ☐ Voice Quavering/shaking
- ☐ Dry mouth
- ☐ Excessive urination
- ☐ Cold hands and feet
- ☐ Blushing/Flushing (hot flashes)
- ☐ Twitches, ticks, spasms
- ☐ Tightness in muscles
- ☐ Soreness in muscles
- ☐ Weakness in parts of the body
- ☐ Pains in heart or chest
- ☐ Excessive alcohol
- ☐ Smoking
- ☐ Itching
- ☐ Sweaty palms
- ☐ Feeling tense or nervous
- ☐ Shakiness/trembling
- ☐ Bad dreams
- ☐ Mind going blank
- ☐ Difficulty sleeping
- ☐ Poor appetite
- ☐ Easily annoyed or irritated
- ☐ Easily crying
- ☐ Loss of sexual function/desire
- ☐ Fatigue
- ☐ Overeating
- ☐ Lump in throat
- ☐ Stuttering
- ☐ Grinding of teeth
- ☐ Heavy feeling in arms and legs
- ☐ Heart racing

- ☐ Tightness of stomach
- ☐ Nausea or upset stomach
- ☐ Trouble getting your breath
- ☐ Extreme fear of places/events
- ☐ Feeling fearful
- ☐ Feeling inferior to others
- ☐ Difficulty concentrating
- ☐ Thoughts of ending your life
- ☐ Worrying or stewing about things
- ☐ Loss of interest in things
- ☐ Difficulty falling asleep
- ☐ Uncontrollable outbursts of temper

Indicate your general feeling of well-being at this time. 0 indicates the worst general feeling, 10 indicates the best you could possibly feel: __________

Length of time since your last physical examination: __________

Please give a brief family history of illness and disease: ______________________________________
____
____

List all medications you are taking presently and medications that you have taken over a long period of time:

Name of drug	Dosage (amount, times per day, length of time)	Reason for taking the medication, does it help?
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

	Yes	No	If yes, why:
Are you on a nutritional diet program?	_______	_______	______________________
Do you eat a high fibre diet?	_______	_______	______________________
Are you taking colon flora? (example: acidophilus or bifidus)	_______	_______	______________________
Does it affect your bowel movements?	_______	_______	______________________
Do you take supplements?	_______	_______	______________________

Please list any allergies you have: ____
____

Please list any surgeries and dates: ____
____

Describe any special problems: ____
____

METABOLIC HISTORY

Underweight ___________
Overweight ___________
Sluggish after meals ___________
Headaches after meal ___________
Low blood sugar ___________

Diabetes ___________
High Cholesterol ___________
Obesity ___________
Anorexia ___________
Bulimia ___________

Habits: Please check the appropriate amount for the following:

	Heavy >3x/wk	Moderate 3x/wk	Light 1-2x/wk
Smoking			
Alcohol			
Coffee			
Cola Drink			
Tea			
Drugs - Specify			
Exercise – Specify type/duration			
Sleep			
Sugar			
Red Meat			
Vegetables			
Grains			
Fruits			

Presently living in the City _________ or Country ___________

Water supply is Tap ___________ or Well ___________ or Bottled ___________

Amount of water consumed daily (not counting juice, tea, coffee, etc.) ___________

History of Mother During Pregnancy:

Did she Exercise ___________ Smoke ___________ Drink ________ Drugs ___________

Regular Diet (briefly describe): ____

____

Were you breast fed? ___________ If so for how long? ________________

Stool Status (regularly)

Hard _______ Firm _______ Soft _______ Loose _______ Smooth _______ Cracks _______

Shape ________________ Length ________________ Width ________________

Does it sink _______ or float _______ small bubbles on it _______ or large _______

Ability: does it slide out _______ or must it be pushed out _______ forcefully _______

Regularity: how often and when: ____

Colour: light _______ medium _______ dark _______ black _______ mucus _______ blood _______

strong odor _______ fluid _______ jelly-like _______

Gas: excessive _______ belching _______ heartburn _______ pressure on chest _______

Anal itching: continuous _______ intermittent _______

Protruding rectum: continuous _______ only after a bowel movement _______

Is there frequent or constant urge for a bowel movement? _______

RELEASE FORM

Informed Consent to Colon Hydrotherapy Treatment

This consent form applies to patients of the Colon Hydrotherapy Treatment at the Armstrong Clinic for Naturopathic Medicine. By consenting to colon hydrotherapy treatment you are authorizing your therapist to have access to your file and personal information. Please ask to review the privacy policy if you have questions about the use of your personal information by the Armstrong Clinic.

Even the gentlest therapies have their complication in certain physiological conditions such as pregnancy, lactation, in patients who are very young/very old, or in people who take multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, lung, heart, liver, or kidney disease. It is very important that you are completely forthright in informing your therapist of any disease process currently going on in your body, if you are on any prescription medication or OTC drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding please inform your therapist immediately.

There are some slight health risks to colon hydrotherapy treatment. These include but are not limited to:
- Aggravation of pre-existing conditions and symptoms
- Allergic reactions
- Fainting
- Loose stools and weight loss

I understand that my therapist keeps a record of services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that I must pay for all tests, in-office prescriptions and services when rendered, without refund after 14 days from purchase date. I understand that my identity will be protected and kept confidential.

I understand that my therapist will answer my questions that I have to the best ability, in a manner, which I can comprehend. I understand that the results are not guaranteed. I do not expect my therapist to be able to anticipate and explain all risks and complications. I will rely on my therapist to exercise the best judgment in my best interests, based on the facts and findings then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: (please list exceptions below)

I intend this consent form to cover the entire course of colon hydrotherapy treatment intended for my current condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time in written format. I understand that if I cancel my appointment with less than 24 hours notice I accept responsibility for all appointment charges.

Colon Therapist: ____

The above named therapist is helping me with natural hygiene at my own request. I understand that if I wish to become a client of Naturopathic Medicine at the Armstrong Clinic, I must complete a New Patient Intake Form and pay the corresponding visit fee.

Name (please print): ____

Signature: ____

Date: ____