



## Colon Hydrotherapy - Pre and Post Recommendations

It is recommended that 24-48 hours prior to your colon hydrotherapy session you consume organic fruits, vegetables and grains. Drinking 6-8 glasses of water a day will also assist in the cleansing process, on the day of your treatment eat lightly, such as vegetables, fruits and juices and also limit your water intake. If possible try to refrain from food or drinks within 2 hours of your treatment. At the end of your session you may feel relaxed, due to the movements of the colon muscles. It is not uncommon to wait 2-3 days before your first bowel movement after treatment. During this time you may have heightened sensitivities to what you ingest. Consume plenty of water and abstain from consuming gas producing foods. It is extremely important to take a probiotic supplement to re-establish good bacteria in the gut. The probiotic, fibre and other supplements are at the clinic.

Foods and beverages to avoid directly before and after your treatment:

<ul style="list-style-type: none"> <li>. Alcohol</li> <li>. Caffeinated tea and coffee</li> <li>. Chocolate</li> <li>. Desserts</li> <li>. Ice cream</li> </ul>	<ul style="list-style-type: none"> <li>. Pastries</li> <li>. Processed junk food</li> <li>. Bread (whole grain is okay)</li> <li>. Carbonated drinks</li> </ul>	<ul style="list-style-type: none"> <li>. Dairy products</li> <li>. Fried and fatty foods</li> <li>. Pasta (brown rice and kamut okay)</li> <li>. Pizza</li> <li>. Sugar</li> </ul>
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Also avoid eating gas producing foods:

<ul style="list-style-type: none"> <li>. Beans</li> <li>. Brussels sprouts</li> <li>. Cauliflower</li> </ul>	<ul style="list-style-type: none"> <li>. Raw apples</li> <li>. Broccoli</li> <li>. Cabbage</li> </ul>	<ul style="list-style-type: none"> <li>. Peppers</li> <li>. Soy products</li> </ul>
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Beneficial foods to consume before and after treatment:

<ul style="list-style-type: none"> <li>. Apricots</li> <li>. Asparagus</li> <li>. Bananas</li> <li>. Blueberries</li> <li>. Brown and basmati rice</li> <li>. Fish and poultry</li> <li>. Garlic</li> </ul>	<ul style="list-style-type: none"> <li>. Grapes</li> <li>. Green leafy vegetables</li> <li>. Herbal teas (especially peppermint, ginger and chamomile)</li> <li>. Miso soup</li> <li>. Nuts</li> </ul>	<ul style="list-style-type: none"> <li>. Onions</li> <li>. Oranges</li> <li>. Organic vegetables</li> <li>. Seeds</li> <li>. Water</li> <li>. Quinoa</li> <li>. Whole grain bread</li> </ul>
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Natural health therapies that help compliment your treatment:

<ul style="list-style-type: none"> <li>. Deep breathing</li> <li>. Skin brushing</li> <li>. Massage therapy</li> <li>. Infrared sauna treatments</li> </ul>	<ul style="list-style-type: none"> <li>. Castor oil packs</li> <li>. Walking</li> <li>. Yoga</li> </ul>	<ul style="list-style-type: none"> <li>. Abdominal hot packs</li> <li>. Warm Epsom salt baths</li> <li>. Rebounding</li> </ul>
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### 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 debilitating

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:

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

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

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Heavy feeling in arms and legs | <input type="checkbox"/> Extreme fear of places/events | <input type="checkbox"/> Worrying or stewing about things   |
| <input type="checkbox"/> Heart racing                   | <input type="checkbox"/> Feeling fearful               | <input type="checkbox"/> Loss of interest in things         |
| <input type="checkbox"/> Tightness of stomach           | <input type="checkbox"/> Feeling inferior to others    | <input type="checkbox"/> Difficulty falling asleep          |
| <input type="checkbox"/> Nausea or upset stomach        | <input type="checkbox"/> Difficulty concentrating      | <input type="checkbox"/> Uncontrollable outbursts of temper |
| <input type="checkbox"/> Trouble getting your breath    | <input type="checkbox"/> Thoughts of ending your life  |   |

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 _____	Diabetes _____
Overweight _____	High Cholesterol _____
Sluggish after meals _____	Obesity _____
Headaches after meal _____	Anorexia _____
Low blood sugar _____	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:** \_\_\_\_\_