Colonic Irrigation Therapy

Patient Intake Form

Name:_____ Birthday: ____/____/_____
(e.g. Jane E. Doe) mm dd yyyy

Address:_____

City: _____ Province: _____ Postal Code: _____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

Occupation:_____ Referred by:_____

I hereby acknowledge that the services provided through this practitioner are not provided by a certified medical doctor, but that she is a specialist in her field. All treatment plans are suggested guidelines that I am welcome to discuss with my family physician or any other medical professional. If I have any questions regarding these services, I will direct them to the practitioner / therapist.

Signature:_____ Date: ____/____/_____
mm dd yyyy

Please Note: If you require receipts or a year end statement, you must inform the reception staff **each** visit otherwise missed dates may not be available.

These questions are designed to provide your therapist with the basic information needed to give you the most effective professional care you deserve

1. Have you ever received a colonic before? ☐ Yes ☐ No
2. Do you have any of these bowel pattern difficulties?

☐ Constipation	☐ Indigestion	☐ Gas
☐ Diarrhea	☐ Colitis	☐ Bloating
☐ Nausea	☐ Heartburn	☐ Dizziness
☐ Upset Stomach	☐ Other :_____	

3. Do you use enemas, laxatives, or cathartics? ☐ Yes ☐ No
4. Have you had a colon X-Ray? ☐ Yes ☐ No
5. Have you had abdominal or bowel surgery? ☐ Yes ☐ No
6. Have you ever had herpes, sores, venereal warts, or any other tissue disease?
   ☐ Yes ☐ No If yes, which type and when:_____
7. Would you like dietary feedback?
   ☐ Yes ☐ No

8. Do you suffer from any of these ailments?

☐ Fatigue	☐ Poor Eyesight	☐ Hearing loss
☐ Asthma	☐ Colds	☐ Allergies
☐ Back Problems	☐ Respiratory Disorders	☐ Hemorrhoids
☐ Thyroid Deficiency	☐ Diabetes	☐ Acne
☐ Worms	☐ Obesity	☐ Rashes
☐ Skin Problems	☐ Difficulty losing weight	☐ Hypoglycemia

9. Please describe the following components of your stools. These aspects are indicative of your colon health and/or dis-ease. *Please Mark all that apply*

a. How often do you move your bowels?

☐ Every other day ☐Once a day ☐ Twice a day ☐Less often

b. What is the consistency of your stool?

☐ Hard ☐ Firm ☐ Soft ☐Watery

c. What is the texture of the stool?

☐ Smooth and Formed ☐ Thready and loose ☐ Mix of both ☐Other_____

d. What are the contents of the stool?

☐ Blood ☐ Mucus ☐ Fat ☐Undigested Food

e. Describe the width of your stool:

☐ Thin and Stringy ☐ Wide ☐ Pellets ☐Other_____

f. What is the length of your stool?

☐ 3” ☐6” ☐ 12” ☐Varies

g. How does your stool settle?

☐ Float ☐Sink ☐ Both

h. Does your stool have an odour?

☐Yes ☐ No ☐Sometimes

i. What colour is your stool?

☐ Yellowish-Brown ☐Dark Brown ☐ Light Brown ☐ Other_____

j. How much toilet paper do you need following a bowel movement?

☐ None ☐ A little ☐ A lot

k. Do you have any problems with digestion that require intervention? If so, which vitamins, supplements, or other medicine do you use?

☐ No ☐ Yes; _____

_____

_____