Client Intake Form

Date: _____

Name: _____ Preferred name or nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (Provide A Minimum of Two) Home: _____ Work _____ Cell _____

Email: _____ Referred By: _____

Height: _____ Weight: _____ Birth Date: _____

Have you ever had a colonic before? If so when? _____ Where? _____

Do you know if it was open or closed system? _____ Which? _____

Please list any other types of cleansing experiences: _____

Are you currently under a MD or ND's Care? _____

If yes Please explain

Doctor's Name _____ Telephone No _____

Are you pregnant? _____ What is your Blood Type?(If you know it)

List of all known allergies: _____

List of all surgeries within the last 5 years _____

List all medications _____

Do you currently take a Pro-biotic Supplement? _____

Please put a check by any current condition and a P by any past condition:

__Constipation	__Diarrhea	__Hemorrhoids	__Indigestion
__Belching	__Flatulence/ga	__Ulcers	__Colitis
__Arthritis	__Headaches	__Dizziness	__Allergies
__Parasites	__Yeast infections	__Insomnia	__Irritability
__Diabetes	__Sinus problems	__Herpes	__Parkinson's
__C.F.S/immune disorder	__Cancer	__Cysts/tumors	__Birth control pills
__Antibiotic uses	__Prostate problem	__Liver/gallbladder issue	__Urination problem
__Breast implants	__Psyche disorders	__Dental issues	

Bowel Habits and Elimination

How often do you have a b/m? PER DAY? _____ PER WEEK? _____

Are they spontaneous? (Please tick one): 1.ONLY AFTER EATING 2. REQUIRES STRAINING 3.EFFORTLESS

Do you have hemorrhoids? (YES / NO) _____

Have you ever had rectal bleeding, if yes, when? _____

Do you Use a laxative? _____ Herbal Laxative? _____ Stool softener? _____ Suppositories? _____ Enemas? _____

Diet

List all supplements you are CURRENTLY taking _____

Mark "**Y**" for YES and "**N**" for NO. If YES, list amount and frequency

Coffee _____ Sugar/salt cravings _____ carbonated drinks/soda _____

Teas _____ Plain water intake per day _____ Vegetarian/Vega _____

Diet programs (ATKINS, SOUTH BEACH, RAW FOODS ETC.) _____

Wheat and dairy products _____

General

Exercise (type and frequency) _____

Stress Reduction (type + frequency) _____

Have you have dental work done in the last 6 months? _____

How many silver/mercury fillings do you have in your mouth? _____

On a scale for1-10, what is your commitment level to getting healthy _____
(10 being the highest commitment)

Cancellation Policy: Cancellations or changes to scheduled appointments must be made at least 24 hours in advance of the scheduled appointment. Otherwise, you will be billed for the cost of service as a cancellation charge. If you are calling after business hours, please leave a message on our voicemail indicating your appointment cancellation.

Disclaimer: Colon Hydrotherapy is not intended to replace the relationship with your primary health care providers and my consultation as a Colon Hydro therapist is not intended as medical advice. It is intended as a sharing of knowledge and information from my education, research, training, and experience. As a Colon Hydro therapist, I encourage you to be open to new information on the effectiveness of colon hydrotherapy and the fundamental role of diet, exercise, supplementation, stress management and emotional and mental work. I encourage you to make your own health care decisions based upon your research and in partnership with your primary health care providers, ND, MD or otherwise. The information and service provided is not used to prescribe, recommend, diagnose or treat a health problem or disease. It is not a substitute for medical care.

I have read and understand the Cancellation Policy and Disclaimer Information,

_____

SIGNATURE/DATE

Medical Release Form

Dear Doctor,

Your Patient has contacted me requesting attendance in our colon Hydrotherapy program. This is a simple, gentle procedure with warm, purified water infused into the rectum via disposable tubing. Our instrument is FDA cleared and we use hospital grade disposable tubing and disinfectant.

In order to provide this service, it is necessary for him/her to have a complete physical to rule out any contraindications below. Please screen this person for colon hydrotherapy based on the list of contraindications below. We usually suggest a series of three sessions as a beginning protocol. I will gladly collaborate with you about further sessions based on outcome. Please provide me with a list of all prescription medications/supplements your patient is taking at this time and then conditions they treat.

The following is a list of contraindications for colon hydrotherapy:

Uncontrolled Hypertension	Congestive Heart Failure
Cirrhosis of the Liver	Carcinoma of the Colon
History of Aneurysm/Blood Clots	Fissure/Fistula
Severe Anemia	Pregnancy/First & Last Trimester
GI Hemorrhage/Perforation	Abdominal Hernia
Bleeding/Inflamed Hemorrhoids	Recent Abdominal Surgery
Renal Insufficiency	Active Diverticulitis, Colitis, IBS

Please provide Name and telephone number of emergency contact:
Name:_____ Telephone Number_____

Thank You,
Wendy S. Kurtz
Certified Colon Hydrotherapist
Well with Wendy
6302 Falls Road, Baltimore, MD 21209
(410) 277-1556
Wendy@WellwithWendy.com

I certify That patient _____ does not have any of the above contraindications and that it is safe for him/her to receive colon hydrotherapy.

Signed: _____ License NO:_____
Print Name: _____ Date:_____

If you are choosing to self treat, please sign and date below.

Signed:_____ Date:_____