

THE SOMA DETOXX SPA

COLON HYDROTHERAPY INTAKE FORM

Please complete the following questions carefully. All data is confidential to ensure your privacy

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation _____

Birth Date _____ Height _____ Weight _____ Female ___ Male _____

Marital Status Single _____ Married _____ Divorced _____ Widowed _____

Domestic Partnership _____ #Children _____

Home # _____ Work # _____ Cell # _____

Email address _____ May we contact you at this address? _____

Would you like to receive newsletters? Yes _____ No _____

Emergency Contact _____ Phone # _____

How did you learn about our service? Personal referral _____ Doctor/Practitioner _____

Print Ad _____ Internet _____ Other _____

Who may we thank for the referral? _____

Medical Care: Date of most recent visit to a Primary Care Physician (PCP) _____

Are you currently receiving healthcare by a MD/ND/Homeopath doctor (s)? _____

If so, please explain: *(Blood Sugar or Thyroid issues, High Blood Pressure or Cholesterol issues, etc.)*

Do your records need to be shared with others? _____ If yes, Whom? _____

Is Colon Hydrotherapy part of a protocol that a doctor or other healthcare professional has referred or

Prescribed for you? _____

Doctor's Name _____ When? _____

Type of doctor PCP _____ Gastroenterologist _____ Proctologist _____ other _____

Why? _____

Outcome _____

COLON HYDROTHERAPY INTAKE FORM

Allergies: List all known: _____

Parasites _____ Do you know you have parasites? _____ If yes, Describe: _____

Back Issues: _____ Do you have any problems/pain in the lower back (lumbar region)? _____
 If yes, describe _____

Abdominal area surgeries: *Circle all that applies* C-Section Gallbladder Gastric Bypass Hysterectomy
 Lap Band Vaginal Mesh Other _____

If yes, to any of the above, do you feel that you have had a change in bowel habits? _____

Colonic History: Have you ever had a Colonic before? _____ If so, when? _____

If yes, please describe your experience: _____

Type of device used (Colonic system) *circle all that applies.* Closed Open Gravity Not Sure

Other forms of cleansing you are using or have used: _____

Digestion: How is your digestion? *Circle all that applies.*

Adequate Poor Acid Reflux Bloating Burning/pain in stomach Indigestion Ulcers

Any other complaints? _____

Have you seen a doctor about them? _____

Medications & Supplements: List all you now take regularly including over the counter _____

Do you take digestive aids? _____ If yes, describe: _____

When was the most recent time you took antibiotics? _____ Why? _____

Bowel Habits: How often do you have a bowel movement? 3 per day 2 per day 1 per day skips days

How are your bowel eliminations normally? (*Circle the best response*) Requires Straining Effortless

When? Only after eating Varies (Describe) _____

Amount: normal too little too large **Consistency:** normal too hard very soft diarrhea

Color: brown black whitish greenish **Other:** lot of mucus lots of gas foul smell

Is the gas related to certain food (s)? _____ If so, describe: _____

Do you have bowel problems? _____ Do you feeling your bowel movements are incomplete? _____

COLON HYDROTHERAPY INTAKE FORM

Describe complaints: _____

Have you seen a doctor about them? _____

Do you use a stool softener or laxative? _____ Herbal laxative? _____ Suppository? _____

Product name (s): _____

If yes, how often? _____ If yes, used for how long (days, months, years)? _____

Do you have hemorrhoids or other rectal problems (itching, fissures, etc.)? _____

If yes, describe: _____

If yes, have you been seen by a doctor? _____

Exercise: Describe your regular routine in the table below

Type of exercise	Frequency	Duration

Energy: On a scale from 1 to 10 where 1= “can’t get out of bed” and 10= “optimal energy”

Please rate your normal energy level: _____ Any relation to food or drinks? _____

If yes, describe examples: _____

Diet: What type of diet best describes your **general dietary habits?** (*Circle the best response*)

Junk food/fast food eater combination (from junk food to health conscious) vegetarian

Vegan raw macrobiotic natural food eater (over 50% organic) health conscious

How many servings of **fruits** do you eat per day? _____

How many servings of **vegetables** do you eat per day? Raw _____ Cooked _____

How much **dairy** do you eat per day? _____ How much **meat** do you eat per day or week? _____

Dietary Goal: My diet **goal** is to be: (*Circle the best response*)

Combination (from junk food to health conscious) Vegan raw macrobiotic Vegetarian

Natural food eater (over 50% organic) Health conscious

Water: How much water do you drink per day? _____ glasses or _____ ounces

Water Source: Tap (from city or well) Bottled Filtered Boiled Whatever is available

COLON HYDROTHERAPY INTAKE FORM

Describe your typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Smoking: Do you currently smoke? _____ If yes, how much? _____ How long? _____

Alcohol: Do you currently drink? _____ If yes, how much? _____ How long? _____

Stress: On a scale from 1 to 10 where 1 = "is mellow" and 10 = "Stressed Out"

Please rate your current stress level: _____ what are the main sources of your stress? _____

Do you notice changes in your bowel habits when you make any changes to exercise, diet, water intake, and stress? _____ If so, please explain: _____

For women pre-menopausal: **Monthly cycle:** Do you experience PMS? _____

Are your periods more than 6 days? _____ Are you susceptible to chronic yeast infections? _____

What do you hope to achieve from this colon hydrotherapy appointment? _____

My signature below indicates I have honestly answered all of the questions above and supplied any additional relevant information within this intake form.

Client Name (Signature) _____ Date: _____

Client Name (Printed clearly) _____

****Reminder: Please stop eating 2 hours prior and stop drinking 1 hour prior to your appointment****

CONTRAINDICATIONS * * * Absolute contraindications prohibit treatment altogether. For example, colon hydrotherapy is absolutely contraindicated for patients with pronounced rectal bleeding. The following are absolute contraindications for colon hydrotherapy, and is NOT advised. Once they have subsided or been eliminated, colon therapy may be indicated. Abortion (less than 6 months) Anal Fissure/Fistula (a tear in the colon) Anemias (Severe) Aneurysm Cirrhosis Colon Cancer (see below) Colon Surgery (less than six months post-op: see below) Colostomy Crohn's disease (in the acute inflammatory or bleeding stages) Epilepsy GI Hemorrhage/Perforation Heart Disease(Severe, Uncontrolled Hypertension; Congestive Heart Failure)

COLON HYDROTHERAPY INTAKE FORM

Hemorrhoids (severe or bleeding [minimal bleeding is okay]) Hernia (abdominal/inguinal) History of seizures
Kidney Dialysis Miscarriage (less than 6 months) Pregnancy (up to 4 months) Recent heart attack Rectal

Bleeding (except for minor hemorrhoids) Renal Insufficiency Tumor in the Rectum or Large Intestine
Ulcerative colitis (active or bleeding) The following are relative contraindications for colon hydrotherapy. A
physician prescription is necessary. Crohn's Disease Acute Colitis Severe Diverticulosis / Acute Diverticulitis
Colon Cancer (need MD approval on integrity of colon) Colon Surgery (need MD approval on integrity of
colon)

RELEASE STATEMENT:

I acknowledge that *THE SOMA DETOXX SPA* and staff members are not medical doctors. I understand that staff members may provide nutritional and other health related information to help me attain and maintain my best health. All suggestions are designed to help me move towards my best state of health through personalized recommendations in lifestyles, exercise, health habits and advanced nutrition. I understand that staff members of *THE SOMA DETOXX SPA* do **NOT** diagnose, treat, or claim to cure any illness or disease.

I have been made aware of all contraindications for colon hydrotherapy and am here on this day and any subsequent visit by my choice and solely on my own behalf. I hereby release and discharge the staff of THE SOMA DETOXX SPA from any and all claims which I or my agents ever had, now have or may have relating to or arising out of services provided or recommendation that I have received. I acknowledge that it is my responsibility to consult with my physician or other health care providers relating to any disease or condition that I may have

I give permission to share my health information with other practitioners and health care professionals who are also providing services for my care.

I have read this informed consent and understand it. I am not a minor (under the age of 18).

I am signing this release voluntarily.

_____ Date: _____
Client Name (Signature)

Client Name (Print clearly Please)