Intake Form

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Name:	Date:
Address:	Phones: Home / Work / Cell
City, Postal Code:	Single Married Divorced Widowed
Email:	# of children: ages:
Birth date: Age:	Name of physician:
Occupation:	Referred By:
Emergency Contact Person:	Emergency Contact Phone Number:

What health conditions are you currently being treated for and by whom? ____

____

Contraindications for Colon Hydrotherapy

A contraindication is any indication or symptom that makes it inadvisable to use a particular therapy. The following are contraindications for colon hydrotherapy. **If any of these apply to you, you may not be eligible for colon hydrotherapy sessions at the present time.** If you have any of these contraindications, you may still be eligible to receive colon hydrotherapy once they have subsided or been eliminated. **Circle all that apply to you:**

Abdominal Hernia

Abdominal Surgery

Acute Abdominal Pain

Acute Crohn's Disease

Cancer of the Colon or Gastro Intestinal (GI) Tract

Carcinoma of the Rectum

Congestive Heart Failure

Diverticulitis

Fissures or Fistulas

History of Seizures

Intestinal Perforations

Pregnancy

Recent Colon or Rectal Bleeding

Renal Insufficiency

Severe Hemorrhoids

Ulcerative Colitis

Uncontrolled Hypertension

bowel movements/day ____ circle all that apply: firm runny incomplete explosive thin thick well formed long (6 inches +)

What do you hope to achieve from this session? ____

____

Disclaimer: Colon Hydrotherapy is not intended to replace the relationship with your primary health care providers and my consultation is not intended as medical advice. The sessions are intended as a sharing of knowledge and information from my education, training, and experience.
As a Colon Hydrotherapist, I encourage you to be open to new information on the effectiveness of colon hydrotherapy and the fundamental role of diet, exercise, stress management, 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 services provided is not used to prescribe, recommend, diagnose or treat a health problem or disease and is not a substitute for medical care.
I understand and acknowledge that, in undertaking colon hydrotherapy with Ulla Devine, I am doing so at my own risk. It is with this understanding that I voluntarily sign this release and waiver.

Signed: ______________________________ Date: ____________________

This part is optional; however it will give me a better idea on how to assist you with your healing.

Have you experienced or do you experience any of the following : use P for PAST symptoms

Arthritis

Back and Neck aches, injuries and pain

Bad Breath

Brain Fog (loss of concentration)

Candidiasis (yeast overgrowth)

Depressions

Diarrhea

Fatigue (low energy)

Headaches

Heavy Mucus Production

Haemorrhoids

Indigestion (heart burn/acid reflux)

Intestinal Gas (Bloating)

Irritable Bowel Syndrome (IBS)

Kidney/Bladder Infection

Parasites

Sinus Congestion

Skin Disorders

Spastic Colon

Weight Issues

Other

Please describe your present and historical use of the following:

Antibiotics:
Birth Control:
Chemical Laxatives:
Tobacco:

Coffee:
Pharmaceutical and/or recreational drugs:

Are you pregnant, or is there any possibility of being pregnant? Yes/No **Are you breastfeeding? Yes/No**

Have you ever had abdominal surgery (including C-sections)? Yes/No **If so, what type, how many and when?**

List any known allergies: ______________________________

Do you have pain in any areas of your abdomen or bowel? Yes/No If yes give details: ______________________________

Are there any traumatic events (surgeries, drug reactions, life trauma, and major illnesses) that you feel might have caused, or contributed to your health problems?

Are you presently or have you ever been exposed to any toxic chemical, solvents, tobacco smoke, or any other possible toxins at home and at work?

Do you have any silver amalgam fillings? How many? ____________ When removed? ____________

Please circle/list all medications and supplements you are taking:

Fiber (psyllium / flax / other ___________________) probiotics enzymes vitamins ______________________________

Other: ____

____

Circle all that apply to your diet: Raw Foods Eggs Dairy Meat Flour products/Bread Sugar Artificial Sweeteners

Soy Products Fried Foods Fast Foods Cookies/Sweets Junk Foods Organically grown fruits and vegetables

Sensitivities to the following foods: ____

Past dietary habits (including childhood diet): ____

Estimate your DAILY liquid intake in cups for each:

Water	Soda	Herbal Tea	Alcohol
Juice	Coffee	Black Tea	Other

Eating Behaviors: circle all that apply overeating binging anorexia bulimia late night eating

Eating when: in pain fatigued constipated emotionally upset not hungry depressed

Do you eat slowly and chew well? _______

Are you able to eat/drink what you intuitively feel is right for you? ________

Describe your exercise habits: ____

____

Describe other types of bodywork you currently receive and have received in the past? What worked for you?

____

Rate the stress level in your life on a scale from 1-10 (10 being the highest): _____

What is the main reason for your stress? ____

What steps are you taking to decrease your stress levels? ____

How do you feel about the state of your health? What about it do you want to change? ______________________________

____

Rate your level of commitment to getting healthy on a scale from 1-10 (10 being the highest): _________

All of the information provided above is to my knowledge correct and current. Initals: ____________ **Date:** ___________