

COLON THERAPY INTAKE FORM

To help us serve your health needs, please complete the following information as accurately as possible. Thank you!

PERSONAL INFORMATION

Name _____ Age _____ M__ F__ Today's Date (Mo/Day/Year) _____
How would you prefer to be addressed in our office? _____ Birth Date (Mo/Day/Year) _____
Home Address _____ City _____ Postal Code _____
Occupation _____ Work Phone _____ Home Phone _____
Email Address _____ Do you have Extended Coverage? Yes__ No __
How did you hear about us? Word of Mouth ____ Advertisement ____ Website ____ Other _____

*Please fill in the information requested below. **NOTE:** All information will be kept strictly confidential*

What health concerns/problems brought you to this office today? _____

MEDICAL HISTORY - If you are currently experiencing any of the following symptoms, please indicate by putting a "C" on the appropriate line. If any of the following symptoms have been experienced in the past, please indicate by putting a "P".

- | | | |
|--|--|---|
| <input type="checkbox"/> Adhesions | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Injuries (recent) |
| <input type="checkbox"/> Anal Fissure/Fistula | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Aneurysm (abdominal) | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Kidney Dialysis |
| <input type="checkbox"/> Anorexia / Bulimia | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Leaky Gut Syndrome |
| <input type="checkbox"/> Blood Pressure __ High __ Low | <input type="checkbox"/> Dysentery | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Bowel Impaction/Obstruction | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Polyps |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gas / Flatulence | <input type="checkbox"/> Pregnancy (current) |
| <input type="checkbox"/> Candida | <input type="checkbox"/> Gastroenteritis | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Headaches | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Colon Surgery | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Surgery (abdominal, colon, rectal) |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Hemorrhoids (Painful or Bleeding) | <input type="checkbox"/> Terminal Illness |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hernia (unrepaired abdominal /
inguinal) | <input type="checkbox"/> Ulcerative Colitis |

Other (Please explain) _____

SURGERIES: (Date/Type of Surgery) _____

MEDICATIONS: (Type) _____

PERSONAL HEALTH HABITS

Height _____ Current Weight _____ lbs Ideal weight _____ lbs. Maximum Weight _____ Year _____

Smoker: Yes__ No__ Smoked for _____ years Amount per Day _____ Year Stopped, If Applicable _____

Alcohol Use: Yes__ No__ Type of Alcohol Preferred _____ Frequency _____

Recreational Drug Use: Yes __ No __ Type _____ Frequency _____

Coffee: Yes__ No__ _____ Cups per day Tea: Yes__ No__ _____ Cups per day

Diet: Are there any food groups you avoid? Yes__ No__ If "Yes", what _____

Do you exercise regularly? Yes__ No__ Type _____ Duration _____ Frequency _____

Hobbies _____

Additional Information _____



Client requests that the therapist insert the speculum. ____ Yes ____ No

Signature of Client _____

Date _____



24 HOUR CANCELLATION POLICY

I UNDERSTAND THAT BY SCHEDULING AN APPOINTMENT WITH CHANTAL DAVID OR SHARI MANHAS AT THE ARBOUR WELLNESS CENTRE, I AM ENTERING INTO A CONTRACT TO APPEAR AT A MUTUALLY AGREED-UPON TIME.

- I AGREE TO GIVE 24 WEEKDAY HOURS ADVANCE NOTICE IF I AM UNABLE TO APPEAR FOR MY APPOINTMENT FOR ANY REASON.
- I AGREE TO COMPENSATE THE ARBOUR WELLNESS CENTRE FOR THE TIME THAT WAS SET ASIDE FOR ME IF I DO NOT PROVIDE SUCH NOTICE.
- I AM AWARE THAT THIS IS STANDARD PRACTICE FOR SMALL PRIVATE PRACTICES AND AM IN ACCORD WITH THE POLICY.

Signature of Client _____

Date _____