Better Ur Belly

CLIENT INTAKE FORM & WAIVER

NAME: _____ DATE: _____

ADDRESS: _____CITY: _____ POSTAL CODE: _____

HOME PHONE#_____ CELL PHONE#_____ BIRTHDATE_____

EMAIL ADDRESS: _____

BUSINESS#_____ OCCUPATION_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

STOOL INDICATORS (CHECK WHICH APPLY)

Bowel Movements: Per Day_____ Per Week_____

What is the consistency? Thin___ Watery___ Well Formed___ Hard___ Mucous___ Strong Smell___ Oily___

Floating___ Describe Colour_____

Any other colon problems now or in the past? _____

Office use: _____

_____

_____

_____

_____

DO YOU EXPERIENCE THE FOLLOWING DIFFICULTIES (CHECK WHICH APPLY)?

Constipation___ Bloating___ Gas___ Heartburn___ Burping___ Diarrhea___ Hemorrhoids___ Fatigue___

Abdominal Pain___ Headache___ Joint Pain___ Rectal Bleeding___ Food Allergies___ Allergies___ Food Restrictions___

If yes to Allergies/Restrictions please specify:

_____

Office use: _____

_____

_____

_____

_____

HEALTH INFORMATION

Are you on any medications(Y/N) _____ If YES, please list_____

_____

Do you take Natural Supplements(Y/N) ___ If YES, please list _____

_____

Have you had colonics before? (Y/N) ___ When? _____ How many? _____

Other cleansing experiences include? _____

Chemical laxatives? _____

Office use: _____

_____

_____

Do you presently have, or have you had any of the following conditions? If in the past, how long ago?

Cancer of the colon or GI tract	YES/NO	AIDS/STD	YES/NO
Acute abdominal pain	YES/NO	Vascular aneurysm	YES/NO
Recent history of GI bleeding	YES/NO	Renal insufficiency	YES/NO
Congestive heart failure	YES/NO	Epilepsy or psychoses	YES/NO
Uncontrolled hypertension	YES/NO	Cirrhosis	YES/NO
History of seizures	YES/NO	Carcinoma of the rectum	YES/NO
Abdominal surgery	YES/NO	Severe hemorrhoids	YES/NO
Diverticulitis	YES/NO	Intestinal perforation	YES/NO
Recent heart attack	YES/NO	Fissures or fistula	YES/NO
General debilitation	YES/NO	Abdominal Hernia	YES/NO
Recent colon or rectal surgery	YES/NO	Pregnancy	YES/NO
Infectious diseases	YES/NO		

Diagnosed Health Conditions: _____

_____

_____

CHECK OFF THE ITEMS YOU CONSUME THE MOST OF:

Red meat ___ Poultry ___ Fish ___ Vegetables ___ Fruit ___ Dairy ___ Wheat ___ Fast food ___ Sweets ___

Coffee ___ Tea ___ Alcohol ___ Pop ___ How many glasses of water do you drink in a day? _____

Colon Hydrotherapy is a very safe and non-threatening procedure that has been performed for hundreds of years.

Fortunately, our office provides a machine operated unit, sterilized H20, and disposable treatments kits.

I fully understand that I cannot hold Mary Ann Sorokan and/or Debbie Ottenbreit responsible or liable for any form of malpractice and /or any medial conditions, as a result of the treatment provided.

I accept total responsibility for my own healthcare and maintenance.

_____ (Print Name) Date_____

_____(Signature)

All information will be held in confidence. This information may help you therapist to assist you better in your quest for optimal colon hydrotherapy results. It is not intended to diagnose or prescribe and is not a replacement for your regular medical attention by your physician.

24 Hour Cancellation Policy in effect. You will be charged for missed appointments.