Better Ur Belly

CLIENT INTAKE FORM & WAIVER

NAME: _____ DATE: _____

ADDRESS: _____CITY: _____ POSTAL CODE: _____

HOME PHONE#_____ CELL PHONE#_____ BIRTHDATE_____AGE___

EMAIL ADDRESS: _____

BUSINESS#_____ OCCUPATION_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

EMERGENCY CONTACT NAME _____ PHONE #_____

WHAT BRINGS YOU HERE? _____

_____

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_____

DO YOU EXPERIENCE THE FOLLOWING DIFFICULTIES (CHECK THOSE THAT APPLY)?

Constipation:	_____	Daily	_____	Weekly	_____	Occasionally	_____
Bloating:	_____	Daily	_____	Weekly	_____	Occasionally	_____
Gas:	_____	Daily	_____	Weekly	_____	Occasionally	_____
Heartburn:	_____	Daily	_____	Weekly	_____	Occasionally	_____
Burping:	_____	Daily	_____	Weekly	_____	Occasionally	_____
Diarrhea:	_____	Daily	_____	Weekly	_____	Occasionally	_____
Abdominal Pain:	_____	Daily	_____	Weekly	_____	Occasionally	_____
Rectal Bleeding:	_____	Daily	_____	Weekly	_____	Occasionally	_____
Hemorrhoids:	_____	Daily	_____	Weekly	_____	Occasionally	_____
Joint Pains:	_____	Daily	_____	Weekly	_____	Occasionally	_____
Body Aches:	_____	Daily	_____	Weekly	_____	Occasionally	_____
Headaches:	_____	Daily	_____	Weekly	_____	Occasionally	_____

HEALTH INFORMATION

Any other colon problems now or in the past? _____

_____

_____

_____

Have you had colonics before? _____ When? _____ How many? _____

Other cleansing experiences include? _____

Chemical laxatives? _____

Are you on any medications? _____ If YES, please list_____

_____

Do you take Natural Supplements? _____ If YES, please list _____

_____

Food Allergies_____

Allergies_____

Food Restrictions_____

Do you presently have, or have you had any of the following conditions (check those that apply)? If in the past, how long ago?

Cancer of the colon or GI tract	___	How long ago?	AIDS/STD	___	_____
Acute abdominal pain	___	_____	Vascular aneurysm	___	_____
Recent history of GI bleeding	___	_____	Renal insufficiency	___	_____
Congestive heart failure	___	_____	Epilepsy or psychoses	___	_____
Uncontrolled hypertension	___	_____	Cirrhosis	___	_____
History of seizures	___	_____	Carcinoma of the rectum	___	_____
Abdominal surgery	___	_____	Severe hemorrhoids	___	_____
Diverticulitis	___	_____	Intestinal perforation	___	_____
Recent heart attack	___	_____	Fissures or fistula	___	_____
General debilitation	___	_____	Abdominal Hernia	___	_____
Recent colon or rectal surgery	___	_____	Pregnancy	___	_____
Infectious diseases	___	_____	Children	___	_____

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 Melissa Stamnes responsible or liable for any form of malpractice and /or any medical 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.