HEALTHY SPIRIT
Colon Hydrotherapy

Please complete the following health-related questions. All information is kept confidential.

Date: _____ Name_____ Date of Birth _____ Gender (M or F)

Address _____ City /State /Zip_____

Home #_____ Work #_____ Cell #_____

E-mail_____ Occupation_____

How did you find out about us?

☐ Boston Yellow Pages
☐ Internet/Website search
☐ Spirit of Change Ad
☐ Earth Star Ad
☐ Practitioner *(name & specialty)*_____
☐ Healthy Spirit client *(name)*_____
☐ Friend *(name)*_____
☐ Other_____

Health:

Is this your first Colon Hydrotherapy session? ☐ Yes ☐ No If not, where and when was your most recent visit?

_____

Why are you seeking treatment? _____

What, if any, is your prior experience with colon cleansing?

☐ Fasting ☐ Juicing ☐ Herbs ☐ Health Spa _____ ☐ Other _____ ☐ None

What other alternative therapies have you tried or are currently doing? _____

Are you presently under the care of a physician? ☐ Yes ☐ No If yes, please provide the name, address and phone number.

_____

My intestinal and/or digestive complaint is: Indicate C = Current Condition P = Past Condition O = Ongoing Condition

____ Colitis	____ Constipation	____ Diarrhea	____ IBS	____ Diarrhea & Constipation
____ Fistula	____ Gas/Bloating	____ Diverticulitis/osis	____ Ulcer	____ Fatigue After Eating
____ Parasites	____ Lactose Intolerance	____ Cramping	____ Fissure	____ Redundancy/Prolapsus
____ Spastic Colon	____ Gas	____ Hard Stool	____ Hernia	____ Anal/Rectal Bleeding
____ Rectal Pain	____ Reflux/Heartburn	____ Crohn's Disease	____ Hemorrhoids	____ Hungry All The Time
____ Indigestion	____ Atonic Colon	____ Celiac Disease	____ Carcinoma	____ None

Please list any intestinal-related procedures you have had, along with the year it took place:

☐ Barium Enema ____ ☐ Colonoscopy ☐ Sigmoidoscopy ____ ☐ Surgery ____ ☐ Other ____ ☐ None

Have you used: Laxatives? ☐ Now ☐ Past ☐ Never Stool softeners? ☐ Now ☐ Past ☐ Never Enemas? ☐ Now ☐ Past ☐ Never

How many bowel movements do you usually have? # Per day _____ # Per week _____ ___

Do you strain to have a movement? ☐ Yes ☐ No
Does the movement feel complete? ☐ Yes ☐ No
Does your stool . . . Show signs of mucus? ☐ Yes ☐ No
Shows signs of blood ☐ Yes ☐ No
Has a strong odor ☐ Yes ☐ No
Usual Color? _____
Usual Shape? _____
Usual Consistency? _____

Were you hospitalized within the past year? _____ In the past 5 years? ____ Why? _____

Do you use any of the following? How frequently? ☐ Antibiotics _____ ☐ Over-The-Counter Drugs _____ ☐ Steroids _____

☐ Recreational Drugs _____ ☐ Prescribed Birth Control _____ ☐ Other _____ ☐ None

☐ Prescription Drugs (Please List) ☐ Anti-Depressants (Please List) ☐ Supplements (Please List)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please indicate by the appropriate letter key below which conditions are applicable:
C = Current Condition P = Past Condition O = Ongoing Condition

____ Abdominal Gas
____ Allergies
____ Anemia
____ Anorexia
____ Anxiety
____ Appendicitis
____ Arthritis
____ Asthma
____ Auto Immune
____ Bad Breath
____ Belching
____ Bloating
____ Blood Pressure H/L
____ Bulimia
____ Burning/Itching anus
____ Cancer
____ Candida Albicans
____ Chemical Sensitivities
____ Cholesterol High/Low
____ Chronic Fatigue
____ Cirrhosis
____ Depression
____ Diabetes
____ Environmental Sensitivities
____ Epstein-Barr
____ Fainting/Dizziness
____ Fibromyalgia
____ Fistula
____ Fissure
____ Gallstones
____ Headaches/Migraines
____ Heart Condition
____ Heartburn
____ Hepatitis
____ Hernia
____ Herpes
____ Hemorrhoids
____ Hyperthyroid
____ Hypothyroid
____ Hypoglycemia
____ Infertility
____ Insomnia
____ Irritability
____ Kidney Stones
____ Liver Imbalance
____ Low Back Pain
____ Low Libido
____ Lung Conditions
____ Lyme Disease
____ Lupus
____ Metal Poisoning
____ Menopause
____ Nausea
____ Nerve Disorder
____ Parasites/Fungi
____ PMS
____ Polymyalgia
____ Prostate
____ Sinus
____ Skin Condition
____ Ulcers
____ Urinary Tract Infection
____ Varicose Veins

Diet: Using the following key, please indicate your dietary usage.

H = Heavy *(5 – 7 times a week)* **M** = Moderate *(2 -4 times a week)* **L** = Light *(once a week or less)* **N** = Never *(really, never!)*

_____ Alcohol
_____ Algae
_____ Antacids
_____ Aspirin
_____ Beans
_____ Bread
_____ Caffeinated Coffee
_____ Caffeinated Tea
_____ Carbonated Water
_____ Chocolate
____ Dairy
____ Decaffeinated Coffee / Tea
____ Eggs
____ Fatty Foods
____ Fish
____ Flax Fiber
____ Fried Foods
____ Fruit
____ Gum
____ Ice Cream
____ Junk Food
____ Nuts / Seeds
____ Organic Foods
____ Pasta
____ Poultry
____ Processed Foods
____ Protein Shakes
____ Psyllium Fiber
____ Red Meat
____Salt
____ Smoothies
____ Soda
____ Soy
____ Sugar
____ Tobacco/cigarettes
____ Vegetables
____ Water
____ Wheat/flour products
____ Whole Grains
____ Yogurt

Briefly describe your typical dietary intake:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Do you have any food cravings? ☐ Yes ☐ No What? _____

Lifestyle:

How do you relax? _____ What forms of exercise do you enjoy? _____

Have you ever traveled abroad? _____ Do you practice: ☐ Meditation ☐ Prayer ☐ 12 Step-Program ☐ Other _____

Are there other areas of your life/lifestyle that you feel would be appropriate for us to know in order to better meet your needs, such as any excessive or unusual mental or physical stress? All information is strictly confident.

_____

Rates, Policies, Contraindications, and Disclaimer for Colon Hydrotherapy

It is our honor to be of compassionate and professional service to you while you are in our care. To ensure your safety and maintain the highest standards of practice, we have listed our business fees and policies for your review prior to receiving our services. Please contact the office with any questions at 781-860-5116.

Rates for Sessions

- $125 for 1 hour session
- $175 for 1.5 hour

First-time Clients

- $175 for 1 hour session plus ½ hour consultation

Series Prices For Payment In Advance (*A Series is a Commitment to You and Your Health*!)

- $500 for 4 (1.5hr and 3/1hr)
- $450 for 4 ($112.50 each)
- $1070 for 10 ($107 each)
- $1940 for 20 ($97 each)

** Series must be used within one year* ** No refunds are available with series* ** Non-transferable*

You also Understand and Agree to the Following:

- Appointments are considered confirmed when scheduled

- 24 hours notice is kindly requested for all cancellations and rescheduling of appointments. If I do not give 24 hours notice for a missed appointment, I know that I will be charged $50.00.

- Payment is expected at the time of service. Discounted visits are sold in series of 4, 10 or 20 sessions, and are prepaid.

- $25 Returned Check Fee

Contraindications - If you have any of the following conditions, please discuss with the Colon Hydrotherapist prior to scheduling any appointment or if in doubt, check with your physician, as a prescription may be necessary. While you are ultimately responsible for your healthcare choices, you are encouraged to share this list with your primary health care providers for their review and approval.

☐ Severe hemorrhoids	☐ Fissures/Fistulas	☐ Severe anemia
☐ Aneurysm	☐ Carcinoma of the colon	☐ Severe Ulcerative colitis
☐ Crohn's Disease	☐ Abdominal hernia	☐ 1st and 3rd trimester pregnancy
☐ Severe diverticulitis	☐ Renal insufficiency	☐ Cirrhosis of the liver
☐ Uncontrolled hypertension	☐ Congestive heart failure	☐ Recent colon surgery (less than 3 months)
☐ GI hemorrhage/perforation		☐ None

Disclaimer - Colon Hydrotherapy is not intended to replace the relationship with your primary health care providers. The consultation is not intended as medical advice but as a sharing of knowledge and information from my education, research, experience and community. As a Colon Hydrotherapist, I encourage you to be open to new information on the effectiveness of Colon Hydrotherapy and the foundational role of diet, exercise, supplementation, stress management and emotional work. I encourage you to make your own health care decisions based upon your research and in partnership with your primary health care providers. The information and service provided is not used to prescribe, recommend, diagnose or treat a health problem or a disease. It is not a substitute for medical care. If you have or suspect you may have a medical condition, you should consult your primary health care providers.

Name_____Date_____