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 your stool . . . Show signs of mucus? ☐ Yes ☐ No
Shows signs of blood ☐ Yes ☐ No
Has a strong odor ☐ Yes ☐ No

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

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

Briefly describe your typical dietary intake:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

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

<u>Lifestyle:</u>

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

- $110 for 1 hour session
- $155 for 1.5 hour

First-time Clients

- $155 for 1 hour session plus ½ hour consultation

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

- $441 for 4 (1.5hr and 3/1hr)
- $400 for 4 ($100 each)
- $935 for 10 ($93.50 each)
- $1700 for 20 ($85 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_____