

Confidential COLON HYDROTHERAPY INTAKE FORM

dragonflymedicinehouse.ca



Please complete the following questions carefully.

All data is confidential to ensure your privacy

Name: _____

Street Address: _____

City: _____ Prov: _____ Code: _____

Cell # _____ Home # _____

Email address _____

May we contact you at this email address? _____

Would you like to receive our email newsletters? Yes _____ No _____

Occupation _____

Birth Date _____ Height _____ Weight _____ Female _____ Male _____

Marital Status Single _____ Married _____ Divorced _____ Widowed _____

Domestic Partnership _____ #Children _____

Emergency Contact _____ Phone # _____

How did you learn about our service? Personal referral _____ Doctor/Practitioner _____

Google Business _____ Website _____ Yellow Pages _____ Yelp _____ Facebook _____ Other _____

Who may we thank for the referral? _____

Health Questions:

Medical Care: Date of most recent visit to your Family Physician _____

Are you currently receiving healthcare by a Naturopath/Homeopath doctor(s)?

Please name _____

If so, please explain: *(Blood Sugar or Thyroid issues, High Blood Pressure or Cholesterol issues, etc.)*

Referral:

Do your records need to be shared with others? _____ If yes, Whom? _____

Is Colon Hydrotherapy part of a protocol that a doctor or other healthcare professional has referred or

Prescribed for you? _____

Doctor's Name _____ When? _____

Type of doctor _____

Allergies: List all known food sensitivities _____

Health concerns: List top concerns _____

Parasites: _____ Do you know you have parasites? _____

If yes, Describe: _____

Back Issues: _____ Do you have any problems/pain in the lower back (lumbar region)? _____

If yes, describe _____

Abdominal area surgeries: *Circle all that applies* C-Section Gallbladder Gastric Bypass Hysterectomy

Lap Band ___ Vaginal Mesh ___ Colon _____ Small Intestine _____ Endometrial _____

Other _____

If yes, to any of the above, do you feel that you have had a change in bowel habits since then? _____

Colon History: Have you had a colon x-ray? _____ When? _____

Have you had a colonoscopy? _____ When & Why? _____

Results _____

Colon Therapy: Have you ever had a Colonic before? _____ If so, when? _____

Where? _____

If yes, please describe your experience: _____

Type of device used? *Circle all that applies* Woods Gravity Machine Do-It-Yourself Not Sure

Other forms of cleansing you are using or have used: _____

Digestion: How is your digestion? *Circle all that applies.*

Adequate Poor Acid Reflux Burping Bloating Burning/pain in stomach Indigestion Ulcers

Do you have discomfort above your navel _____

Have you seen a doctor about these symptoms? Type of Doctor _____

Diagnosis: Has a medical doctor diagnosed you with any disease or condition?

Medications: List all you now take regularly, including over the counter _____

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Do you take anything for digestion? _____ If yes, describe: _____
Do you take anything for your bowels? _____ If yes, describe: _____
When was the most recent time you took antibiotics? _____
Why? _____

Bowel Habits: How often do you have a bowel movement? *Circle how many*
3 per day 2 per day 1 per day skips days once a week every 2 weeks
How are your bowel eliminations normally? Requires Straining _____ Effortless _____ Loose _____
Diarrhea _____ Constipation _____ Alternating Constipation/Diarrhea _____
Incomplete Feeling _____ Thin _____ Abdominal Bloating _____ Gas _____
Beige in color _____ Undigested Food in stools _____ Mucus in stools _____
Abdominal Discomfort Below Navel _____ Actual pain there _____
Have you seen a doctor about these symptoms? _____ Family Doctor _____
GI Specialist _____ When _____ Recommendations _____
Diagnosis from Specialist _____

Do you have hemorrhoids or other rectal problems (itching, fissures, etc.)? _____
If yes, describe: _____
Do you use a stool softener or laxative? _____ Herbal laxative? _____ Suppository? _____
Product name(s): _____
If yes, how often? _____ If yes, used for how long (days, months, years)? _____

Exercise: Type _____ Frequency _____

Energy: On a scale from 1 to 10 where 1= "can't get out of bed" and 10= "optimal energy"
Please rate your normal energy level: _____ Any relation to food or drinks? _____
If yes, describe examples: _____

Diet: What type of diet best describes your **general dietary habits?** (*Circle the best response*)
Junk food/fast food eater combination (from junk food to health conscious) vegetarian
Vegan raw macrobiotic natural food eater (over 50% organic) health conscious
How many servings of **fruits** do you eat per day? _____
How many servings of vegetables do you eat per day? Raw _____ Cooked _____
How much **dairy** do you eat per day? _____ How much **meat** do you eat per day or week? _____

Dietary Goal: My diet goal is to be: *(Circle the best response)*

Combination (from junk food to health conscious) Vegan raw macrobiotic Vegetarian
Natural food eater (over 50% organic) Health conscious

Water: How much water do you drink per day? _____ glasses or _____ ounces

Water Source: Tap (from city or well) Bottled Filtered Boiled Whatever is available

How much coffee daily? _____

Cannabis _____ **Alcohol** _____

Smoking: Do you currently smoke? _____ If yes, how much? _____ How long? _____

Alcohol: Do you currently drink? _____ If yes, how much? _____ How long? _____

Stress: On a scale from 1 to 10 where 1 = "is mellow" and 10 = "Stressed Out"

Please rate your current stress level: _____ what are the main source of your stress? _____

If you're stressed, level 5 or more, what step(s) are you taking to reduce your stress?

Do you notice changes in your bowel habits when you make any changes to exercise, diet, water intake, and stress? _____ If so, please explain: _____

For women pre-menopausal: **Monthly cycle:** Do you experience PMS? _____

Are your periods more than 6 days? _____ Are you susceptible to chronic yeast infections? _____

Goals:

What do you hope to achieve from this colon hydrotherapy appointment? _____

Concerns: Do you have any specific concerns? _____ If yes, explain:

My signature below indicates I have honestly answered all of the questions above and supplied any additional relevant information within this intake form.

* * * I am aware of the following CONTRAINDICATIONS * * *

A contraindication is any indication or symptom that makes it inadvisable to use a particular therapy. Absolute contraindications prohibit treatment altogether. For example, colon hydrotherapy is absolutely contraindicated for patients with pronounced **rectal bleeding**. **Relative contraindications** involve a risk/benefit ratio. In the case of colon cancer, colon hydrotherapy's ability to eliminate poisonous toxins is evaluated against possibly weakening the already-compromised colon walls. The following are absolute contraindications for colon hydrotherapy. If you have any of these, colon hydrotherapy is NOT advised.

Please circle if any of these apply to you during the past few months.

Once reactionary symptoms have subsided or been eliminated, colon therapy may be indicated.

The following are Absolute Contraindications:	Heart Disease (severe uncontrolled hypertension; congestive heart failure, tachycardia, heart surgery)	Tumor in the Rectum or Large Intestine
Abortion (less than 6 months)	Heart attack recent	Ulcerative colitis (active or bleeding)
Anal Fissure/Fistula (a tear in colon)	Hemorrhoids (severe or bleeding [minimal bleeding is okay])	The following may be Relative Contraindications for colon hydrotherapy.
Anemias (severe)	Hernia (abdominal/inguinal)	
Aneurysm	History of seizures	
Cirrhosis	Kidney Dialysis	Crohn's Disease
Colon Cancer (see below)	Miscarriage (less than 6 months)	Acute Colitis
Colon Surgery (less than six months)	Pregnancy (up to 4 months)	Severe Diverticulosis / Acute Diverticulitis
Colostomy	Rectal Bleeding (except for minor hemorrhoids)	Colon Cancer
Crohn's disease (in the acute inflammatory or bleeding stages)	Renal Insufficiency	
Epilepsy		
GI Hemorrhage/Perforation		

I proceed and take responsibility at my own risk.

Date: _____

Client Name (Signature)

Client Name (Printed clearly)

****Reminder: Please stop eating 2 hours prior and stop drinking 1 hour prior to your appointment****

RELEASE STATEMENT:

I acknowledge that *DRAGONFLY MEDICINE HOUSE* and all staff members are not medical doctors. I understand that *JOANNE BROPHY* may provide nutritional and other health related information to help me attain and maintain my best health. All suggestions are designed to help me move towards my best state of health through personalized recommendations in lifestyles, exercise, health habits and advanced nutrition. I understand that *DRAGONFLY MEDICINE HOUSE & JOANNE BROPHY* do **NOT** diagnose, treat, or claim to cure any illness or disease. I am here to accept assistance with personal hygiene.

I have been made aware of all contraindications for colon hydrotherapy and am here on this day and any subsequent visit by my choice and solely on my own behalf. I hereby release and discharge *JOANNE BROPHY* and *DRAGONFLY MEDICINE HOUSE* from any and all claims which I or my agents ever had, now have or may have relating to or arising out of services provided or recommendation that I have received. I acknowledge that it is my responsibility to consult with my physician or other health care providers relating to any disease or condition that I may have

I give permission to share my health information with other practitioners and health care professionals who are also providing services for my care.

I have read this informed consent and understand it. I am not a minor (under the age of 18).

I understand the above Financial & Cancellation Policy and will abide by these charges.

I am signing this release voluntarily. I have read the Privacy Policy and Disclaimer on the website dragonflymedicinehouse.ca

_____ Date: _____

Client Name (Signature)

Client Name (Print clearly Please)