Flowing Waters Wellness Center

(confidential intake form)

Name____Male/Female__________Date______________

Address____________________________________City__________________ST_____Zip__________

PHONE-Home__________________________Cell__________________________Email____________________

Occupation____Date of Birth______________

Marital Status______How many children do you have?______ If you are a woman: Are you pregnant?_____What trimester?__________

Ever had a Colonic before?________If so, when?______________Other forms of Detox/Cleanse____________________

How did you learn of our services?____

Are you under a Doctor's care?________If so, please explain_______________________________________

Doctor's Name:______________________________Phone________________ Major Physical Complaints______________

____

List any surgeries you have had____

List all medications & supplements you now take regularly (including over the counter)______________________________

____

List all known allergies____

How many bowel movements per day do you usually have?_____________Do you have to strain to have a bowel movement?__________

Do you use a stool softener or laxative?______________Herbal laxative?________________Suppository?__________________

Do you have hemorrhoids or other rectal problems?____

If so, please explain____

Have you ever had a barium enema?__________________________If so, when?______________________________

WHAT WOULD YOU LIKE TO RECEIVE FROM THIS APPOINTMENT? Is there anything specific you would like to work on during the session? WHAT IS YOUR GOAL?

____

24 Hour Cancellation Policy: If you must cancel your appointment, please call at least **24 hours** in advance or a **$50.00** charge will be added to your bill. If there is no answer when you call, you can leave a message and we will acknowledge that you have cancelled your appointment so that we may reschedule.

Please initial______________________________

Colon Therapy Procedure: I have been informed and agree to self-insertion and self-retraction of the speculum.

Please initial______________________________

Colon Therapy Senate Bill 577: I have read and understood that the services provided at this center are in compliance with section 2053.6 of the Business and Profession Code of the State of California.

Please initial ______________________________

If you are a Federal, State or Local agent, upon entering these premises you must declare same or under the Bivens Act, Article 42, be held personally and individually liable.

Signature ______________________________________**Date** ____________________

For the following please write 1 – 2 or 3
If it does not apply please leave blank
1. **If symptom is occasional/mild**
2. **If symptom is frequent/moderate**
3. **If symptom is severe/constant**

Answers

	Headaches		**Muscle / Joint Aches**		**Edema/ Swelling**
	Insomnia		**Arthritis**		**Hemorrhoids**
	Dizziness		**Low Back Pain**		**Colitis**
	Fatigue		**HEP-C / HIV**		**Diverticulitis**
	Depression		**Liver Disorder**		**Skin Irritations/Rashes**
	Excess Gas/ Bloating		**Lung Disorder**		**IBS**
	Burping		**Bladder Disorders**		**Foggy Headed**
	Digestive Problems		**Menstrual Problems**		**Yeast Infections**
	Double/blurred vision		**Prostate Problems**		**Mood Swings**
	Falling hair excessive		**Anemia**		**Sugar cravings**
	Eat when nervous		**Neuropathy**		**Foot Fungus**
	Bitter metallic taste		**Diabetes**		
	Bad Breath		**Seizures**		
	Constipation		**High/Low Blood pressure**		

Please check whether you have any of the following

YES	NO	Contraindications	YES	NO	Contraindications	YES	NO	Contraindications
		Severe Cardiac Disease			Ulcerative colitis			Recent colon surgery
		Aneurysm			Crohn's disease			Renal insufficiency
		Severe Anemia			Cirrhosis			Fissures/ Fistulas
		GI hemorrhage/perforation			1st trimester of pregnancy			Organ Transplant
		Severe hemorrhoids			Advanced pregnancy			
		Severe diverticulitis			Abdominal hernia			

Please read before signing:

I have honestly answered all above questions and am not intentionally withholding information about my health.

Signature: ____ Date: ____________