North Nanaimo Medical Clinic – *Wellness Team*
Unit 195, Rutherford Road, Nanaimo, BC. V9T 4K6
250-729-4969

Chantal David, CT, Spa Therapist
Melanye Walker, CT, Bowen Therapy Practitioner

COLON THERAPY INTAKE FORM

To help us serve your health needs, please complete the following information as accurately as possible. Thank you!

PERSONAL INFORMATION

Name_____ Age _____ M__ F__ Today's Date (Mo/Day/Year)_____

How would you prefer to be addressed in our office? _____ Birth Date (Mo/Day/Year) _____

Home Address_____City_____ Postal Code_____

Occupation_____ Work Phone_____ Home Phone_____

Email Address (for clinical purposes only) _____ Check box ☐ if you would like to receive our newsletter – currently twice per year

How did you hear about us? Word of Mouth ____ Advertisement____ Website ____ Other _____

Please fill in the information requested below. **NOTE:** *All information will be kept strictly confidential*

MEDICAL HISTORY - If you are currently experiencing any of the following symptoms, please indicate by putting a "**C**" on the appropriate line. If any of the following symptoms have been experienced in the past, please indicate by putting a "**P**".

__	Adhesions	__	Constipation	__	Hypoglycemia
__	Allergies	__	Crohn's Disease	__	Injuries (recent)
__	Anal Fissure/Fistula	__	Diabetes	__	Irritable Bowel Syndrome
__	Aneurysm (abdominal)	__	Diarrhea	__	Kidney Dialysis
__	Anorexia / Bulimia	__	Diverticulitis	__	Kidney Problems
__	Bloating	__	Diverticulosis	__	Leaky Gut Syndrome
__	Blood Pressure __ High __ Low	__	Dysentery	__	Parasites
__	Bowel Impaction/Obstruction	__	Fibromyalgia	__	Polyps
__	Cancer	__	Gas / Flatulence	__	Pregnancy (current)
__	Candida	__	Gastroenteritis	__	Rectal Bleeding
__	Chronic Fatigue Syndrome	__	Headaches	__	Skin Problems
__	Colon Cancer	__	Heart Problems	__	Stomach Problems
__	Colon Surgery	__	Hepatitis	__	Surgery (abdominal, colon, rectal)
__	Colostomy	__	Hemorrhoids (Painful or Bleeding)	__	Terminal Illness
__	Colitis	__	Hernia (unrepaired abdominal / inguinal)	__	Ulcerative Colitis
				__	**Other** (Please explain)

_____

SURGERIES: (Date/Type of Surgery)

_____

_____

MEDICATIONS: (Type)

_____

PERSONAL HEALTH HABITS

Height_____ Current Weight_____lbs Ideal weight_____lbs. Maximum Weight_____Year _____

Smoker: Yes__ No__ Smoked for _____years Amount per Day_____ Year Stopped, If Applicable_____

Alcohol Use: Yes__ No__ Type of Alcohol Preferred_____ Frequency_____
Recreational Drug Use: Yes __ No __ Type_____ Frequency_____

Coffee: Yes__ No__ _____Cups per day Tea: Yes__ No__ _____Cups per day

Diet: Are there any food groups you avoid? Yes__ No__ If "Yes", what_____

Hobbies_____

What is your main reason for seeking colon hydrotherapy as a part of your self-care? _____

DIGESTIVE MAINTENANCE

Probiotics:

Are you currently taking probiotics? **Y** / **N** Brand Name _____

Daily Dose _____ Do you keep your probiotics refrigerated? _____

Digestive enzymes:

Are you currently taking a digestive enzyme? **Y** / **N**

Type & Brand Name _____

Water Consumption:

How much per day _____ Type _____

Exercise: Do you Exercise regularly? **Y** / **N** Type _____

Duration _____ Frequency_____

Bowel Movements:

Frequency _____ Is your stool hard and dehydrated or soft? _____

Do you have to strain to have a movement? **Y** / **N**

Have you ever had **colon hydrotherapy** before? **Y / N** If yes, when? _____

Did you complete a “series” of treatments at that time? **Y / N** How many sessions did you do consecutively? _____

What is your **goal** or **intention** for today’s session?_____

How committed are you to actively participating in improving your health and wellbeing?

Not at all 1 2 3 4 5 6 7 8 9 10 100% Committed

Are you interested in acquiring tools or learning about programs that could support you in sustaining continued wellness ? Y / N

Are you currently suffering from any of the following?

******** *Please note that the following are contraindications for receiving colon hydrotherapy****

Congestive Heart Failure	Y / N	Surgery to abdomen in past 2 months	Y / N
Aneurysm	Y / N	Uncontrolled high blood pressure	Y / N
Kidney insufficiency	Y / N	Inguinal hernias	Y / N
Rectal fistulas	Y / N	Colon or rectal tumors	Y / N
Pregnancy	Y / N	Rectal bleeding	Y / N

I, the undersigned, consent to Colon Hydrotherapy treatment through the use of sterile equipment and warm filtered water. I understand that these procedures are for the purpose of detoxification and cleansing of the colon and are not intended to take place of medical care or medications. I clearly confirm that I do not have any contraindications to Colon Therapy (as noted above). I understand that I can discontinue my treatments anytime. I give permission that the therapist providing my treatments may perform the insertion of the disposable speculum used during treatment. I agree to pay my account in full after every treatment.

POLICY

I UNDERSTAND THAT BY SCHEDULING AN APPOINTMENT WITH CHANTAL DAVID OR MELANYE WALKER AT THE NORTH NANAIMO MEDICAL CLINIC, I AM ENTERING INTO A CONTRACT TO APPEAR AT A MUTUALLY AGREED-UPON TIME.

*• I AGREE TO GIVE **24 WEEKDAY HOURS** ADVANCE NOTICE IF I AM UNABLE TO APPEAR FOR MY APPOINTMENT FOR ANY REASON.*

• I AGREE TO COMPENSATE THE NORTH NANAIMO MEDICAL CLINIC FOR THE TIME THAT WAS SET ASIDE FOR ME IF I DO NOT PROVIDE SUCH NOTICE.

• I AM AWARE THAT THIS IS STANDARD PRACTICE FOR SMALL PRIVATE PRACTICES AND AM IN ACCORD WITH THE POLICY.

*ALL PACKAGES AND/OR PREPAID TREATMENTS ARE VALID FOR UP TO **1 YEAR** AFTER DATE OF PURCHASE.*

PACKAGES ARE TO BE USED BY ONE CLIENT ONLY AND ARE NOT TO BE SHARED OR TRANSFERRED. THIS ENSURES THAT EACH CLIENT IS RECEIVING HIS OR HER BEST RESULTS BY ADHERING TO A PROTOCOL THAT HAS BEEN RECOMMENDED BY A PROFESSIONAL COLON THERAPIST BASED ON HER CLIENT'S INDIVIDUAL NEEDS.

Signature of Client _____ **Date** _____

"It is with great pleasure that we offer this service to you, with the intention of facilitating a positive healing experience resulting in improved physical, mental and spiritual wellness along with a renewed sense of joy for life ☺"