

NEW CLIENT INTAKE FORM

DATE _____

NAME _____ DATE OF BIRTH _____

ADDRESS _____ AGE _____

CITY, STATE, ZIP _____

EMAIL ADDRESS _____

HOME PHONE _____ CELL PHONE _____

OCCUPATION _____

How did you hear about NATURAL HEALTH and WELLNESS? _____

Reason for your visit? _____

What are your top 2 health goals you wish to address at today's visit?

1. _____

2. _____

Do you have chronic health problems or other diagnoses?

Are you currently under a doctor's care? Explain and list name of attending physician. _____

Do you have lab findings to support any diagnosis? _____

Are you experiencing or have you experienced in the past any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> NAUSEA | <input type="checkbox"/> VOMITING | <input type="checkbox"/> NUMBNESS, TINGLING, OR PARALYSIS |
| <input type="checkbox"/> FEVER | <input type="checkbox"/> EDEMA | <input type="checkbox"/> DEPRESSION WITH SUICIDAL THOUGHTS |
| <input type="checkbox"/> PAIN | <input type="checkbox"/> BLOOD IN THE URINE | <input type="checkbox"/> FREQUENT URINATION |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> NIGHT SWEATS | <input type="checkbox"/> UNUSUAL ABDOMINAL BLOATING |
| <input type="checkbox"/> BLEEDING OF ANY KIND | <input type="checkbox"/> BLACK TARRY STOOLS | <input type="checkbox"/> UNUSUAL SHORTNESS OF BREATH |
| <input type="checkbox"/> RECENT FAINTING OR LOSS OF CONCIIOUSNESS | | <input type="checkbox"/> LUMPS, SWELLING, SORE LYMPH NODES |

How much water do you drink? _____

Do you drink: Alcohol _____ How much? _____

Coffee _____ How much? _____

Soft drinks? _____ Diet drinks? _____ How much? _____

Do you smoke? _____ If so, how much? _____

How much do you exercise? _____

How much do you sleep at night? _____

Is your sleep restless or disturbed? _____

What is your current level of commitment to addressing these issues?

- I am willing to make any changes and do whatever is necessary
- I am willing to make some changes in my lifestyle to feel better
- I may consider change if absolutely necessary to feel better

When was your last physical exam? _____

When was your last gynecological exam? _____

PLEASE LIST ALL MEDICATIONS YOU CURRENTLY USE, INCLUDING OVER THE COUNTER PRODUCTS SUCH AS ASPIRIN (INCLUDE NAME BRAND, REASON AND DURATION, AND PRESCRIBING PHYSICIAN):

PLEASE LIST ALL SUPPLEMENTS, INCLUDING BRAND NAME, REASON AND DURATION:

Please list your past medical history:

- | | | | |
|---------------------------------------|--|--|------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> CANCER | <input type="checkbox"/> FATIGUE | <input type="checkbox"/> PMS |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> COLON | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> PNEUMONIA |
| <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> DEPRESSION/ANXIETY | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> PROSTATE |
| <input type="checkbox"/> ALZHEIMER'S | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HOT FLASHES | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIARRHEA/CONSTIPATION | <input type="checkbox"/> IBS | <input type="checkbox"/> STD |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> THYROID |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> MIGRAINE | |
| <input type="checkbox"/> OTHER, LIST: | | | |

Family Medical History:

M = Mother F = Father G = Grandparents B = Brother S = Sister C = Children SP = Spouse

___ ASTHMA ___ ARTHRITIS ___ CANCER ___ DIABETES ___ STROKE
___ ALLERGIES ___ ALCOHOLISM ___ HEART DISEASE ___ SEIZURES

RATE CURRENT STRESS LEVEL - 0 - 10 (MILD = 1-3, MODERATE = 4-6, SEVERE = 7-10)

JOB OR SCHOOL ___ FINANCIAL ___
PRIMARY RELATIONSHIP ___ FAMILY/PARENTS/CHILDREN ___
HEALTH ___ OVERALL ___

HAVE YOU EVER USED:

- VITAMIN THERAPY HERBAL MEDICINES HOMEOPATHIC MEDICINES
ACUPUNCTURE SPINAL MANIPULATION COLONIC THERAPY
MASSAGE THERAPY NATUROPATHIC PHYSICIAN

How often do you have a bowel movement and describe a typical bowel movement?

*CONTRAINDICATIONS: MARK AND DATE IF YOU'VE EVER HAD ANY OF THE FOLLOWING:

- Abdominal Hernia Diverticulosis/Diverticulitis
Abdominal Surgery Fissures & Fistulas
Abnormal Distention Hemorrhaging
Acute Liver Failure Hemorrhoidectomy
Anemia Intestinal Perforations
Aneurysm - All Types Lupus
Cancer-type _____ Pregnant (due date _____)
Cardiac Condition Rectal/Colon Surgery
Crohns Disease Renal Insufficiencies
Colitis Taking medications, which may
Dialysis Patient weaken intestinal walls?

Colon Hydrotherapy may not be received if you've had a colonoscopy in the past 90 days!!!

I have not been diagnosed with any contraindications for colonic irrigation. I am aware that the colon hydro therapists are not physicians or nurses and therefore they cannot diagnose, prescribe or treat. The client must insert the rectal tube. I am aware that adverse events such as perforation; injury and illness have been alleged and claimed with the use of colon irrigation and enema devices. If during my self-insertion of sterile rectal tube there is resistance, or if I experience discomfort or pain, I am responsible for stopping my session and immediately notifying the therapist. This facility does not claim to treat any condition or disease.

CLIENT SIGNATURE _____ DATE _____

(Client 18 and under require signature of parent or guardian)