Natural Health & Wellness
Greenwood Village's Premium Alternative Health Center

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:

☐ NAUSEA	☐ VOMITING	☐ NUMBNESS, TINGLING, OR PARALYSIS
☐ FEVER	☐ EDEMA	☐ DEPRESSION WITH SUICIDAL THOUGHTS
☐ PAIN	☐ BLOOD IN THE URINE	☐ FREQUENT URINATION
☐ DIARRHEA	☐ NIGHT SWEATS	☐ UNUSUAL ABDOMINAL BLOATING
☐ BLEEDING OF ANY KIND	☐ BLACK TARRY STOOLS	☐ UNUSUAL SHORTNESS OF BREATH
☐ RECENT FAINTING OR LOSS OF CONCIOUSNESS		☐ 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):

_____

_____

_____

_____

_____

_____

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_____

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

_____

_____

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_____

Please list your past medical history:

☐ AIDS	☐ CANCER	☐ FATIGUE	☐ PMS
☐ ALCOHOLISM	☐ COLON	☐ HEART DISEASE	☐ PNEUMONIA
☐ ALLERGIES	☐ DEPRESSION/ANXIETY	☐ HIGH BLOOD PRESSURE	☐ PROSTATE
☐ ALZHEIMER'S	☐ DIABETES	☐ HOT FLASHES	☐ STROKE
☐ ANEMIA	☐ DIARRHEA/CONSTIPATION	☐ IBS	☐ STD
☐ ARTHRITIS	☐ EMPHYSEMA	☐ LIVER DISEASE	☐ THYROID
☐ ASTHMA	☐ EPILEPSY	☐ MIGRAINE	

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