

COLON HYDROTHERAPY PATIENT PACKET



Healthcare Partners
Family Medicine

Personal Information

Name: _____ Date: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____

Occupation: _____ Place of Employment: _____

Height: _____ Weight: _____ Blood Type: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Number of children (names & ages): _____

Do you have any pets? ___ If so, what kind and what are their names: _____

Who is responsible for this account? _____

Referred by: _____

Who would we contact for you in case of an emergency?

Name: _____ Relationship: _____

Home Phone: _____ Work: _____ Cell: _____

Medical History

Are you under a doctor's care? _____

Doctor's name: _____ Doctor's Phone number: _____

Major physical complaints: _____

Are you pregnant? _____ If yes, please see the receptionist because we cannot administer some services for you at this time.

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Have you had any surgeries?

_____ If yes, when, and please describe: _____

Have you had any accidents? _____ If yes, when and please describe: _____

Have you had any broken bones? _____ If yes, when and please describe: _____

Please list all known allergies: _____

Are you allergic to latex? _____

Please list all medications and supplements you are taking: _____

Are you currently seeing a psychotherapist or attending regular support group meetings? _____

If yes, please explain: _____

Contraindications for Colon Hydrotherapy

- Severe Cardiac disease: e.g. uncontrolled hypertension
- Congestive heart failure of organic valve disease
- Aneurysm
- Severe Anemia
- GI hemorrhage / perforation
- Severe hemorrhoids
- Cirrhosis
- Carcinoma of the colon or rectum
- Fissures / fistulas
- Advanced pregnancy
- Abdominal hernia
- Recent colon or rectum surgery
- Renal insufficiency
- Advanced Crohn's
- Advanced ileitis

CIRCLE any of the conditions listed above which you may have. Colon Hydrotherapy can NOT be done!

Please initial that you have reviewed the contraindication list. _____

Name: _____ **Date:** _____

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Food Consumption / Food Diary

For the food listed below, please indicate the amount of consumption weekly.

(None Light Moderate Heavy)

Sweeteners	Sugar	Honey	Syrup	Tobacco
Coffee	Tea	Soda	Alcohol	Salt
Beans	Salads	Sprouts	Potatoes	Spices
Canned Fruit	Protein bars	Cereals	Cookies	Cakes
Chocolate	Ice Cream	Eggs	Butter	Milk/Dairy
Cheese	Yogurt	Beef	Pork	Poultry
Fish	Shellfish	Bread	Bagels	Oat
Wheat	Barley	Rye	Rice	Pasta
Soy	Corn	Fast Foods	Fresh Fruit	Frozen Fruit
Fresh Vegetables	Frozen Vegetables	Canned Vegetables		

In this section, list the foods you ate yesterday or eat on a typical day. Include everything you ate and drank, listing the amounts. Be specific about the types of food (i.e. white or brown bread, fried potatoes, etc.).

Daily Routine

How do you rate (Light, Moderate, Heavy) the stress in your daily life at:

Home _____ Work _____

How often do you exercise in a week? _____ What type of exercise? _____

What do you do for relaxation? _____

What do you do for recreation? _____

Dietary Habits

Where do you eat the majority of your meals? Home: _____ % Restaurant: _____ %

How much water do you drink a day?

8 oz (cup) _____ 16 oz (pint) _____ 32 oz (quart) _____ 64 oz (1/2 gal) _____ 128 oz (gal) _____

What do you hope to accomplish from your appointment today?

Patient's Initials: _____

Name: _____ Date: _____

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Health Conditions

Please place a **check mark** if you have had any of the following **in the last 30 days**. Place an **X** if you have had any of the following in the past.

- | | | |
|---|---|--|
| <input type="checkbox"/> recent constipation | <input type="checkbox"/> family history of colon cancer | <input type="checkbox"/> heart disease |
| <input type="checkbox"/> chronic constipation | <input type="checkbox"/> underweight | <input type="checkbox"/> cancer |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> overweight | <input type="checkbox"/> Candida |
| <input type="checkbox"/> parasites | <input type="checkbox"/> diabetes | <input type="checkbox"/> body odors |
| <input type="checkbox"/> colitis | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> heartburn |
| <input type="checkbox"/> ulcerative colitis | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> obesity |
| <input type="checkbox"/> bowel impactions | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> frequent headaches | <input type="checkbox"/> fainting spells |
| <input type="checkbox"/> diverticulitis | <input type="checkbox"/> migraine headaches | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> bloody or black stools | <input type="checkbox"/> history of seizures | <input type="checkbox"/> bloating |
| <input type="checkbox"/> fistula or fissures | <input type="checkbox"/> insomnia | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> ulcers | <input type="checkbox"/> irritability | <input type="checkbox"/> anemia |
| <input type="checkbox"/> hernia | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> Chron's disease | <input type="checkbox"/> chronic cough | <input type="checkbox"/> emphysema |
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> painful menstruation | <input type="checkbox"/> bronchitis |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> vaginal discharge | <input type="checkbox"/> asthma |
| <input type="checkbox"/> change in stool | <input type="checkbox"/> breast pain | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> gas, belching | <input type="checkbox"/> poor circulation | <input type="checkbox"/> depression |
| <input type="checkbox"/> low blood sugar | <input type="checkbox"/> painful urination | <input type="checkbox"/> liver trouble |
| <input type="checkbox"/> kidney failure | <input type="checkbox"/> blurred vision | <input type="checkbox"/> bruise easily |
| <input type="checkbox"/> gallbladder disease | <input type="checkbox"/> kidney stones or infection | <input type="checkbox"/> dry skin |
| <input type="checkbox"/> prostate trouble | <input type="checkbox"/> enlarged thyroid | <input type="checkbox"/> skin rash |

Colon Hydrotherapy is an effective method of cleansing your large intestine (colon). Your therapist does not diagnose disease or prescribe medication. It is your responsibility to provide pertinent health information and to inform the therapist of any changes.

RELEASE: I understand and agree that Colon Hydrotherapy services provided by this State Certified Colon Hydrotherapist are provided pursuant to and in accordance with the laws of the State of Florida governing Colon Hydrotherapy and that full and complete medical history disclosure is essential in providing such therapy. I agree to hold harmless, release and indemnify this State Certified Hydrotherapist with all relevant information necessary for the proper application of Colon Hydrotherapy and I expressly give my permission for this State Colon Hydrotherapist to provide such therapy.

Signature: _____ **Date:** _____

Patient's Initials: _____