Intake Form

Name: ______________________________ Date: ____________

D.O.B. __________ Age: _____ Sex: M F Height: ______ Weight: _______

Address: ____

City: ____________________ State: __________ Zip: __________

Phone: (H) ______________ (C) ______________ (W) ______________

Email: ____________________ Occupation: ____________________

Would you like to be emailed about future specials and promotions? Yes No

Emergency Contact: ____________________ Phone: ______________

Source of Referral (Please specify): ______________________________

Have you ever had a colonic? Yes No If yes, when? ____________________

Other forms of cleansing you are currently using or have used: ______________

What would you like to achieve with colon hydrotherapy? ______________

____

Are you under the care of a Medical Doctor or Alternative Health Care Provider? Yes No

If yes, please explain: ______________________________________

Doctor's name: ____________________ Phone: ______________

Please list all known allergies: ______________________________

For Women: Are you pregnant? Yes No Childbirth History: ______________

Please list all surgeries and dates: ______________________________

____

Please list all prescription or over-the-counter medications you are taking: ______________

____

Please list all supplements you are taking: ______________________________

____

Bowel Habits

How many bowel movements per day do you usually have? ________________ Per week? ________________

Do you have hemorrhoids or other rectal problems (please explain)? ______________________________

Have you ever had any rectal bleeding? Yes No If yes, when? __________________________

Circle if you use: laxatives stool softeners suppositories enemas

If so, product names: ______________________________________ How often? ________________

Have you ever had a colonoscopy? Yes No If yes, when ______________________________

Please check "Y" for YES or "N" for NO. If yes, please list frequency and amount

☐ Y ☐ N Water________________	☐ Y ☐ N Vegetables________________
☐ Y ☐ N Carbonated drinks____________	☐ Y ☐ N Fruits____________________
☐ Y ☐ N Coffee______________	☐ Y ☐ N Sweets__________________
☐ Y ☐ N Alcohol______________	☐ Y ☐ N Fried food________________
☐ Y ☐ N Dairy products____________	☐ Y ☐ N Red meat_________________
☐ Y ☐ N Refined flour_____________	☐ Y ☐ N Stress__________________
☐ Y ☐ N Whole grains______________	☐ Y ☐ N Exercise_________________

Do you have any other concerns or conditions/ illnesses that we should know about? ________________

____

Your appointment time has been reserved for you. In the event you need to cancel a scheduled appointment, please provide our office with a 24 hour cancellation notice. Not arriving for a scheduled appointment and appointments changed or cancelled with less than a 24 hour notice are subject to a $40 missed appointment fee. If you are late, a shortened appointment time may be necessary so please be sure to arrive on time. All payments are due at the time of visit. All Checks are subject to a $25 returned check fee. Please initial ________

I am aware that this facility does not have a licensed medical doctor on staff. I understand that Colon Hydrotherapists are not physicians and therefore do not diagnose, prescribe, or offer medical advice. I understand that this facility does not claim to cure or treat any illness or disease. I am aware that colon hydrotherapy is a natural hygienic service intended to cleanse the colon, and that it is not a treatment or a replacement for medical care by my medical provider. I have consented to receive colon hydrotherapy offered at Radiance Cleansing Center and I am here on this day and any subsequent visit by my own choice and will. I have honestly answered all questions and disclosed my health history. If during the session I experience any discomfort or pain, I am responsible for immediately stopping my session. Please initial ________

SIGNATURE ______________________________________ DATE ________________