Radiance
CLEANSING CENTER

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 will be charged price of the missed appointment. 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 _____

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THE FOLLOWING ARE **CONTRAINDICATIONS** FOR COLON HYDROTHERAPY

Please check all that apply

- ☐ Severe Anemia
- ☐ Aneurysm
- ☐ Carcinoma of the colon or rectum
- ☐ Severe Cardiac Disease
  (uncontrolled hypertension or congestive heart failure)
- ☐ GI Hemorrhage/Perforation
- ☐ Active/Severe Hemorrhoids (inflamed, painful or bleeding)
- ☐ Crohn's Disease
- ☐ Cirrhosis of the Liver
- ☐ Recent Abdominal or Colon Surgery (within 6 months)
- ☐ Diverticulitis
- ☐ Fissures/Fistulas
- ☐ Pregnancy
- ☐ Abdominal Hernia
- ☐ Renal Insufficiency
- ☐ Kidney Dialysis
- ☐ Ulcerative Colitis
- ☐ Epilepsy/ Seizures

If you have any of the above contraindications you will not be able to receive colon hydrotherapy at this time. You may be able to receive colon hydrotherapy once these conditions have subsided or with a prescription from your medical doctor.

Please sign below confirming you do not have any of the above contraindications for Colon Hydrotherapy.

_____ _____

Client Name (Signature) Date