



Creating *Healthier* Lives

COLON HYDROTHERAPY CLIENT INTAKE FORM

Personal Information

Name: _____ Age: _____
Address: _____
Date of Birth (dd/mm/yy) ___/___/___
City: _____ Province: _____ Postal Code: _____
Height: _____ Weight: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____
Occupation: _____
Referred by: _____ Reason for visit: _____
Physician's Name: _____ Phone Number: _____
Do you have extended health insurance? __ Yes __ No
If yes, please list provider: _____

I would like to be on the clinic's general mailing list to receive clinic information, such as subscriber specials and the clinic newsletter. Please circle YES/NO.

Check if you have currently or have had any of the following:

- | | | |
|--|---|---|
| <input type="radio"/> Arthritis | <input type="radio"/> High Blood Pressure | <input type="radio"/> Recent Accident:
_____ |
| <input type="radio"/> Blood Clots | <input type="radio"/> Infectious Disease | <input type="radio"/> Spinal Injury |
| <input type="radio"/> Bursitis | <input type="radio"/> Varicose Veins | <input type="radio"/> Alcoholism |
| <input type="radio"/> Cancer | <input type="radio"/> Migraine Headaches | <input type="radio"/> Skin problems |
| <input type="radio"/> Diabetes | <input type="radio"/> Ulcers: _____ | <input type="radio"/> Allergies: _____ |
| <input type="radio"/> Epilepsy | <input type="radio"/> Crohn's | _____ |
| <input type="radio"/> Heart Trouble | <input type="radio"/> Colitis | <input type="radio"/> Mobility issues:
_____ |
| <input type="radio"/> T.B. | <input type="radio"/> Appendix Removed | _____ |
| <input type="radio"/> Yeast Infections | <input type="radio"/> Recent Surgery | _____ |
| <input type="radio"/> Vasectomy | | |

Any other considerations or conditions? _____

Have you ever used any of the following in the last year?

- | | | |
|---------------------------------------|---------------------------------|--|
| <input type="radio"/> Antacids | <input type="radio"/> Diuretics | <input type="radio"/> Anti-inflammatory
Drugs |
| <input type="radio"/> Stool Softeners | <input type="radio"/> Steroids | <input type="radio"/> Antibiotics |
| <input type="radio"/> Laxatives | <input type="radio"/> Enemas | |

Have you ever had Colon Hydrotherapy? ___ yes ___ no If yes, when and where?:

List all medications and nutritional supplements you are currently taking:

Additional History for Colon Hydrotherapy Sessions

Your bowel movement (BM) frequency:

2 or more a day 1 per day 4 per week 2 or 3 per week less than 2 per week

Do you have to strain? ___ yes ___ no

Use laxatives? ___ yes ___ no

If yes, Brands(s): _____

Have you had any of the following?

Hemorrhoids When? _____

Rectal Bleeding When? _____

Barium Enema When? _____

Colonoscopy When? _____

Rectal Surgery When? _____

Abdominal Surgery When? _____

Colon Surgery When? _____

Check if you currently have the following:

- | | | |
|--|---|---|
| <input type="radio"/> Bad Breath | <input type="radio"/> BM Difficult/Painful | <input type="radio"/> Colitis |
| <input type="radio"/> Coated Tongue | <input type="radio"/> Stool – Very foul odor | <input type="radio"/> Constipation |
| <input type="radio"/> Swollen Ankles | <input type="radio"/> Burning stomach sensation | <input type="radio"/> Crohn's Disease |
| <input type="radio"/> Hungry between meals | <input type="radio"/> Burning/Itching anus | <input type="radio"/> Ulcerative Colitis |
| <input type="radio"/> Vomiting | <input type="radio"/> Asthma | <input type="radio"/> Diverticulitis |
| <input type="radio"/> Blood in Stool | <input type="radio"/> Bronchitis | <input type="radio"/> Gallbladder Disease |
| <input type="radio"/> Stress | <input type="radio"/> Greasy foods upset | <input type="radio"/> Liver troubles |
| <input type="radio"/> Depression | <input type="radio"/> Chronic fatigue | <input type="radio"/> Abdominal Hernia |
| <input type="radio"/> Allergies | <input type="radio"/> Hay Fever | <input type="radio"/> Diarrhea |
| <input type="radio"/> Indigestion | <input type="radio"/> Difficulty sleeping | |
| <input type="radio"/> Gas | | |

Are you pregnant? Y/N Number of pregnancies: _____

Have had any complications with your current or prior pregnancies: Y/N

If yes, please describe:

Daily and Dietary Habits:

Alcohol:	Heavy	Moderate	Light	None
Coffee:	Heavy	Moderate	Light	None
Tobacco:	Heavy	Moderate	Light	None
Drugs:	Heavy	Moderate	Light	None
Exercise:	Heavy	Moderate	Light	None
Sleep:	Heavy	Moderate	Light	None
Appetite:	Heavy	Moderate	Light	None
Water:	Heavy	Moderate	Light	None

What do you usually eat :

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Any other medical history/medications we should know about?

INFORMED CONSENT

I would like to take this opportunity to welcome you to the clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and supplemental therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history, which may include a physical exam and specific laboratory testing as part of the treatment. Any practitioner you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

Statement of Acknowledgement

I, (printed name) _____ as a patient of this clinic, have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. As the clinic is an integrated health clinic, I recognize that all the practitioners that are working with me will have access to my file. I give my consent to have the Nardella Clinic contact me through e-mail, if necessary. I also recognize that even the gentlest of therapies potentially have their complications in certain physiological conditions, in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from venipuncture or acupuncture; and muscle strains and sprains. I also confirm that I have the ability to accept or reject this care of my own free will and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so declaring.

I understand that, as a patient, **I am responsible for all costs incurred as a result of the decision including, but not limited to; the cost of all procedures involved in the treatment plan, the care provider's time, supplements, supplies and appointments missed or cancelled without sufficient notice (48 hours). I am aware that all telemedicine appointments will be charged to the credit card on file seven (7) days in advance of the appointment.** I am aware that treatments are not covered through Alberta Health Care and may not be covered under private health insurance.

Signature _____ Date _____

Please send intake form to info@nardellaclinic.com or fax to 403-282-0465.

We will review it to ensure you are an appropriate candidate, and give you a call to schedule an appointment.

Clinic Use Only:

Patient is suitable for treatment:

Doctor's Signature