Miranda Naturopathic Clinic

Hollace Burnett-Simmonds
Certified Colon Hydrotherapist

Colon Hydrotherapy Intake Form

Personal Information:

Name: _____ **Address:** _____

City: _____ **Province:** _____ **Postal Code:** _____

Phone number: _____ **Work:** _____ **Cell #:** _____

Email address: _____ **Where may we leave messages? (H, W, C)**

Birth Date: _____ **Age:** _____ Sex (M / F) **Please circle**
(month/day/year)

How did you hear about the clinic? _____

Would you like to receive *Dr. Miranda's Weekly Health Tips:* **YES** **NO**

Emergency Contact Name:

Name: _____ Relationship: _____ Phone: _____

Indicate your main health concerns in order of importance to you:

1. _____ Since When: _____
2. _____ _____
3. _____ _____
4. _____ _____

List any medication or supplements that you are taking: For how long?

_____ _____
_____ _____
_____ _____

Probiotics:

Are you currently taking probiotics? _____ Which company? _____How much? _____

Fiber:

Are you currently taking a fiber supplement? Y / N What fiber? _____

Which company? _____ How much? _____With how much water? _____

Water Consumption:

How much per day? _____ Type? _____

Bowel Movements:

Frequency? _____ Do you have to strain to have a bowel movement? Y / N

Have you ever had Colonics before? Y / N

***** Please indicate which of the following conditions you have experienced in the past or are suffering from currently*****

P for Past / C for Current

Constipation / Gas:	P/C	Asthma:	P/C	Overweight:	P/C
Bloating:	P/C	Allergies:	P/C	PMS:	P/C
Diarrhea:	P/C	Dark Circles Under Eyes:	P/C	Psoriasis:	P/C
Colitis:	P/C	Depression:	P/C	Polyps:	P/C
Cohn's disease Spastic Colon:	P/C	Offensive Body Odour:	P/C	Rectal fissures:	P/C
Irritable Bowel Syndrome:	P/C	Allergies / Hives:	P/C	Rectal itch:	P/C
Diverticulosis:	P/C	Acne / Boils:	P/C	Rosacea:	P/C
Bad breath:	P/C	Abdominal Pain:	P/C	Skin rashes:	P/C
Coated tongue:	P/C	Belching:	P/C	Sinusitis:	P/C
Hemorrhoids:	P/C	Blood in Stool:	P/C	Vomiting:	P/C
Parasites:	P/C	Cancer:	P/C	Ulcers:	P/C
Fatigue:	P/C	Eczema:	P/C	Heartburn:	P/C
Headaches:	P/C	Fibromyalgia:	P/C	Nausea:	P/C
Skin problems:	P/C			Gallstones:	P/C

***** Please note that the following are contraindications for receiving Colon Therapy treatment*****

Are you currently suffering from any of the following?

Congestive Heart Failure	Y / N	Inguinal hernias	Y / N
Surgery to abdomen in past 2 months	Y / N	Rectal fistulas	Y / N
Aneurysm	Y / N	Colon or rectal tumours	Y / N
Uncontrolled high blood pressure	Y / N	Pregnancy	Y / N
Kidney insufficiency	Y / N	Rectal bleeding	Y / N

****

I, the undersigned, consent to Colon Hydrotherapy treatment through the use of sterile equipment and warm filtered water. I understand that these procedures are for the purpose of detoxification and cleansing of the colon and are not intended to take place of medical care or medications. I understand that there is a possibility of minor abdominal discomfort during the treatment. I clearly confirm that I do not have any contraindications to Colon Therapy (as noted above). I understand that I can discontinue my treatments anytime. I agree to pay my account in full after every treatment.

Signature: _____ Date: _____