COLONIC INTAKE FORM

This form is completely confidential. Please submit by email, fax, mail, or in-person before your appointment.

PROFILE:

Name: ____ Gender: ☐ M ☐ F Age: ______

Today's Date: ______/______/______ (dd/mm/yyyy) Date of Birth: ______/______/______ (dd/mm/yyyy)

Address: ____

____

Telephone: (Home) ______-______-______ (Cell) ______-______-______ (Work) ______-______-______

Email: ____

Occupation: ____________________________________ Employer: ____

How did you hear about us? ____

Have you ever had a colon hydrotherapy session? ☐ Y ☐ N When? _________________________________

Why have you chosen to have a colon hydrotherapy session? ____

May we give you appointment reminder calls? ☐ Y ☐ N (phone) ______-______-______

May we leave you phone messages? ☐ Y ☐ N (phone) ______-______-______ ☐ same as above

Name of Medical Doctor / Family Physician: _______________________________ Telephone: ______-______-______

EMERGENCY CONTACT:

Name: ____ Relationship: ______________________________
Telephone: (home) ______-______-______ (cell) ______-______-______ (work) ______-______-______

Please list all current medications (prescription or over-the-counter) and supplements (herbs, vitamins)

Name of Drug / Supplement	Used For	Date Started	Dose / Frequency

List past prescription medications:

____

____

List any known allergies (include drugs, food, environmental, chemical and etc.) and the reaction(s) from them.

____

____

Y = current	N = never	P = past

Good energy? ☐ Y ☐ N ☐ P Rate your energy level: ______/10 (10 = best)

Fatigue: ☐ Y ☐ N ☐ P Rate your stress level: ☐ Low ☐ Average ☐ High ☐ Unbearable

How often do you exercise? _________________________ What type of exercise? _______________________________

How many hours of sleep per night? _________ If waking up frequently, what is the reason? ______________________

How much water do you drink per day? ____________________

Type of water that you drink? ____

Please record your diet for the last 3 days:

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Dinner			

How often do you have a bowel movement? ____________________ Do you use laxatives? ☐ Y ☐ N

Do you tends towards? ☐ constipation ☐ diarrhea ☐ both ☐ Other: _________________________________

What is the color of your stool? ________________________ Any undigested food in stool? ☐ Y ☐ N

What is the shape of your stool? ☐ Well-formed ☐ Ribbon-like ☐ Pellets ☐ Other: ________________________

How many times have you been treated with antibiotics? For what condition(s)?_________________________________

Have you ever used probiotics or yogurt after antibiotic use? ☐ Y ☐ N ______________________________________

What is your greatest health concern? ____

How does it limit you the most? ____

How committed are you towards making valuable changes? ☐ Little ☐ Moderate ☐ Very

Would you be interested visiting with Dr. Cutler in regards to your health concern(s)? ☐ Y ☐ N ☐ Maybe in the future

Is there any other information that you feel is important that has not been covered?

____

____

____

____

CONTRAINDICATIONS FOR COLON HYDROTHERAPY:

(Please check box and date if any of the following apply to you:)

☐	Anal Fissure/Fistula	☐	Anemia (Severe)
☐	Aneurysm	☐	Cardiac disease
☐	Cirrhosis	☐	Colonoscopy (recent)
☐	Colon Cancer	☐	Colon Surgery
☐	Colostomy	☐	Crohn's disease
☐	Diverticulosis/Diverticulitis	☐	GI Hemorrhage
☐	Hemorrhoids	☐	Hernia
☐	Kidney disease	☐	Liver disease
☐	Perforation	☐	Pregnancy
☐	Rectal Bleeding	☐	Surgeries (recent)
☐	Tumor in Rectum/Intestines	☐	Ulcerative colitis

PLEASE SIGN BELOW CONFIRMING THAT YOU DO NOT HAVE ANY OF THE ABOVE CONTRAINDICATIONS

Patient's Signature: ____ **Date:** ____________________

I understand and fully disclose any and all medical treatments that I have had in the past may directly or indirectly be related to me participating in the use of colon hydrotherapy. This may include but is not limited to gastrointestinal evaluations, diagnosis, procedures, medications, surgeries and the like. Also, but not limited to any proctology diagnosis, evaluations, procedures, medications and surgeries.

By signing this form, I am disclosing that I have not had any undisclosed gastrointestinal procedures such as; but not limited to EGD (esophageal stomach scope), colonoscopy, sigmoidoscopy, anal scope and the like. I hereby consent to the services that will be provided as well as my own physical limitations and I agree to assume the risk of accepting this service. I acknowledge if I have any medical conditions that may be affected by the service requested, I will advise and discuss such conditions with the service provider.

I am aware that it is always advisable to consult a physician before undertaking any such service. I have not been diagnosed with any contraindications for colon hydrotherapy. I am aware that colon hydrotherapists are not physicians and therefore do not diagnose or prescribe. I am aware that adverse events such as perforation, injury and illness have been alleged and claimed with the use of colon hydrotherapy. If I experience resistance during the insertion, I will immediately stop my session. If during the session I experience discomfort or pain, I am responsible for immediately stopping my session. I am aware this facility does not claim to cure or treat any condition or disease.

Arriving to your appointment late will simply limit the time for your session. Your session will end on time so that the next patient will not be delayed. If late, it is up to you whether to receive a shortened session or pay for the appointment and reschedule.

I fully understand and accept any and all liability if my previous medical treatments/diagnosis and the likes are not disclosed in writing and placed in my chart. I further release Cutler Integrative Medicine and Kristy Hamann from all harm regarding these issues as stated above.

Patient's Signature: ____ **Date:** ____________________

I have reviewed and answered all questions in regards to this colonic intake form with the patient:

Therapist's Signature: ____ **Date:** ____________________