

Digestive & Therapeutic Wellness Centre
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website: www.colonspas.com
Confidential Intake Form

Date: _____
 How did you hear about us? Web TV Sign Word of Mouth Other?

 Name: _____ Date of birth: _____
 Address: _____ City: _____ Postal code: _____
 Phone: Home: _____ Cell: _____ (Carrier): _-_____

E-mail : _____ Occupation: _____

Please check box if you wish to join our e-mail list and be the first to know about what's going on at the Digestive & Therapeutic Wellness Centre such as specials, promotions, and information of a holistic, nutritional or therapeutic nature in our correspondence or Newsletters.

Please check box to unsubscribe.

Please place a check mark (✓) to indicate your service areas of interest:

Bio Meridian Body Testing:

Food Sensitivity Screening
 Vitamin & Mineral Deficiency Screening
 Parasite & Candida Screening
 Hormonal Balance
 Organ Screening

Services and Therapies:

Colon Hydrotherapy
 BioMeridian Assessments
 Holistic Nutrition Consulting
 Mental Wellness
 Therapy & Counseling Services
 Naturopathic Doctor

Enhancing Wellness:

PARAFLUSH
 Foot Detox Soak
 Foot Detox Wraps
 Organ Detox Wraps
 BACH Flower Remedies- Natural mental wellness
 Mineral Mixtures
 Essential Oil application and products

Massage Therapy
 Hot and Cold Shell Massage
 Micro Blading
 Vegan Spray Tanning

Beauty Services and Products

Facials
 Natural microdermabrasion scrubs
 Peels
 Eyelash extensions

HOLISTICA SKIN CARE

Manicures
 Pedicures
 Medical Pedicure

Lash Tint
Body Wraps
Cellulite and Stretchmark treatments

Waxing
Sugaring

PLEASE TAKE ADVANTAGE OF A FREE CONSULTATION FOR ANY OF OUR SERVICES OR TREATMENTS

What is your #1 health goal or concern at this time?

What symptoms or health concern brings you to this appointment?:

Please list any disease, illness or ailments you have been diagnosed with:

Have you been hospitalized, or had surgery, or any organ(s) removed?

List any medication you are currently taking (prescription and over the counter) along with the reason why you are taking it.

List any supplements you take daily?

Contraindications for colon hydrotherapy and other digestive disorders please mark with a Y or N:

IBS _____ Colitis _____ Crohn's _____ Ulcer _____ Diverticulitis _____ Diabetes _____ Polyps _____

Gallstones _____

Appendicitis _____ Kidney Stones _____ **Anal Fissure** _____ **Colon Cancer** _____ **Surgery** _____

Hernia _____

Renal Failure ____ **Liver cirrhosis** ____ **Hemorrhoids** ____ **Heart Failure** ____ **Are you pregnant?** ____
Intestinal perforation ____

Do you experience digestive difficulties (please check all those that apply):

Bloating ____, Constipation ____, Heartburn ____, Gas ____, Burping ____, Diarrhea ____,
 Abdominal pain ____, Fatigue ____, Headaches ____, Joint Pain ____
 Do you use laxatives? _____ What kind and how often? _____ Do you use antacids?

Stool Indicators

The following are helpful indicators of the health of your bowels as well as your overall health. Under each heading please circle all responses that apply to you over the last 6 months.

Frequenc y	Consistenc y	Contents	Length	Width	Texture	Colour	Time
Daily 1x - 2x - 3 x	Hard, dry	Mucous (white/ yellow)	6" or more	3"+ tubular	Smooth, Well formed	Light to dark brown	5 min or Less
Every 2 days	Firm	Fat floating	3-5" pieces	1" tubular	Thready, loose	Orange/ Yellow brown	5-15 min.
Weekly	Soft	Blood	Less than 3"	Dime thin or Less	Lumps Pressed together	Grey/Green	
Once/wk or less	Loose/ Watery	Bits of food	Chunks/balls	Varies	Varies	Black	

Diet

Are you on a cleanse or special diet? _____ Are you a vegetarian/vegan? ____ For how long?

How much of the following do you drink daily? Water _____(Tap / Bottle/ Filtered) Coffee

Black tea _____ Herbal tea _____ Juice _____ Pop _____ Alcohol _____ Beer _____
Wine _____

How many times in a week do you eat the following foods? Meat (beef/chicken/eggs/fish) _____

Nuts _____

Fruit _____ Vegetables (raw) _____ (cooked) _____ Dairy _____ Baked Goods _____ Beans _____

White Flour products (rice, bread etc.) _____ Whole grains (quinoa, brown rice, oats, barley) _____

Do you have any food allergies?

What foods do you crave?

Chemicals (Yes or No)

Are/were you a smoker? _____ How many daily? _____ For how long? _____ If you quit, when? _____

Do you wear perfume? _____ Spray deodorant? _____ Do you take antibiotics at least once/year?

Drink tap water? _____ Eat organic fruit and vegetables? _____ Use an air purifier? _____

Have you travelled in the last year? _____ Did you get ill on the trip or upon returning home?

Have you done a parasite cleanse? _____ When? _____

Emotions: What is your current level of stress? Minimal _____ Average _____ Considerable _____

Are there any stressful circumstances in your life right now?

How many hours of sleep do you get/night? _____ Do you wake feeling rested? _____

Do you experience (Y or N): Mood Swings? _____ Depression? _____ Anxiety? _____ PMS? _____

Please check (✓) if you are consenting to have email correspondence regarding your Services, Assessments, Consultations or Customized Plans at the Digestive & Therapeutic Wellness Centre. Yes _____ No _____.

I, the undersigned, hereby acknowledge that the personnel at the Digestive & Therapeutic Wellness Centre are not prescribing (ordering for use as medicine) for me at any time, and I will not hold them accountable for such. Any recommendations I receive are not intended as primary therapy for any symptom or disease, but as a means of enhancing the quality of my diet. I understand that Colon hydrotherapy is a professional service which may provide information related to nutritional requirements, however this service is not a tool for the prevention, assessment or diagnosis, or treatment of any

particular illness or disease. The services I receive are initiated at my own request for reasons personal to me. I understand that all sessions and series I purchase are non-refundable and non-transferrable. I am responsible to be at my scheduled appointment on time. If I miss or cancel my appointment without giving 24 hours notice I agree to be charged a \$20 late cancellation fee by the Digestive & Therapeutic Wellness Centre to the valid credit card I have provided on file.

Client signature _____

Date _____

Thank you for your cooperation.

All information in this form will be kept strictly confidential.

Optional client statement: (re nutrition)

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being, and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.