ATLANT HEALTH
WELLNESS CENTER

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New York, NY 10022
Tel: (212) 719-3611

Colonic - New Client Intake Form

Personal History

Name: _____ Date of Birth: ____/____/_____ Age: ____

Address: _____ City: _____ State: _____ Zip Code_____

E-mail: _____ Cell #: _____ Home #: _____

Occupation: _____ How did you hear about us? _____

Emergency Contact: _____ Contact Number: _____

A contraindication is any indication or symptom that makes it inadvisable to use a particular therapy. The following are contraindications for colon hydrotherapy. If any of these apply to you we are not able to treat you with colon hydrotherapy at this time. If you have any of these contraindications you may still be eligible to receive colon hydrotherapy once they have subsided or been eliminated or if you are under the order, guidance and supervision of a qualified physician working with Provence Wellness Center.

Please put an "X" in the appropriate box. If you have a prescription from a doctor showing supervision over services here for a particular condition, please check the box to the right of that condition.

Yes?	No?	Condition	Prescription?
		Cancer of the colon or GI (gastrointestinal) tract	
		Acute abdominal pain	
		Recent history of GI or rectal bleeding	
		History of Seizures	
		Abdominal surgery	
		Recent colon or rectal surgery	
		Diverticulitis	
		Heart problems	
		Vascular Aneurism	
		Epilepsy or psychoses	
		Severe Hemorrhoids	
		Fissures or fistula	
		Pregnancy	
		Ulcerative Colitis	
		Acute Crohn's Disease	
		Abdominal Hernia	

Are you now, or any possibility of being pregnant? Yes/No
Are you breast-feeding? Yes/No
Do you have pain in any areas of your abdomen or bowel? _____
_____

Pertinent Travel History (out of USA, epidemic areas, etc.): _____

_____

_____

Have you ever had colonics? _____ If so, how many? _____ When? _____

Other cleansing experiences? _____

Main problems or concerns for this appointment? _____

_____

Yes?	No?	Condition	Describe
		Candidiasis (yeast overgrowth)	
		Constipation	
		Diarrhea	
		Edema	
		Irritable Bowel Syndrome (IBS)	
		Indigestion (heart burn/acid reflux)	
		Intestinal gas (bloating)	
		Heavy mucus production	
		Hemorrhoids	
		Skin Disorders	
		Headaches	
		Bad breath	
		Arthritis	
		Brain fog (loss of concentration)	
		Fatigue (low energy)	
		Parasites	
		Depression	
		Backaches	
		Kidney/bladder infection	
		Weight issues	

Do you buy organically grown fruits and vegetables? _____, dairy and meat? _____
Circle all that apply in your diet:

Raw foods	Eggs/dairy	Vegan	Vegetarian
Whole foods	Meat	Standard American Diet	

Describe your **daily** liquid intake in ounces (e.g. 8 oz. of water):

Water (filtered?)	Soda	Herbal Tea	Alcohol
Juice	Coffee	Black Tea	Other

Describe your **daily** intake of the following:

Flour products/Bread	Sugar	Artificial Sweeteners	Soy Products
Dairy Products	Meats	Fried Foods	Fast Food

Allergies (include drugs, food, and environmental):

_____
_____
_____

Current Medications **Current Vitamins/Herbs/Supplements**

_____ _____
_____ _____
_____ _____
_____ _____

Please describe your historical use of the following:

- Antibiotics: _____
- Birth Control: _____
- Chemical laxatives: _____
- Tobacco: _____
- Coffee: _____
- Pharmaceutical and/or recreational drugs: _____
  _____

Cleansing Goals:

How do you feel about the state of your health? What/How would you like that to change?

_____
_____

Do you have interest in a specific type of cleanse? _____

Are you and your partner trying to conceive? _____

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* I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder and does not prescribe medical treatment or pharmaceuticals. It has been made clear to me that colon hydrotherapy is not a cure, substitute for medical examination or diagnosis and that it is recommended that I see a physician for any ailments that I might have. I agree that the therapist is helping me with natural hygiene at my request, and is not diagnosing, nor treating disease, nor practicing any form of medicine.

If you need to cancel or reschedule your appointment, please provide 24 hours' notice to avoid incurring the full therapy fee or redemption of Gift Certificates.

All the information provided above is, to my knowledge, correct and current.

Signed _____ Date _____

Thank you for choosing Atlant Health Wellness Center for your detoxification and health maintenance needs. We look forward to sharing with you on your journey to optimum health and well-being!