THE PIPER CENTER
For Internal Wellness

THE PIPER CENTER *for Internal Wellness*
Colonic Intake Form

*Please help us provide you with the most effective service by completing the following questions. All information is kept **confidential.***

Personal Data: (please print)

First Name _____ Last Name _____

Address _____ City/State/Zip _____ _____ _____

Phone Home _____ Work _____ Cell _____ email _____

Occupation _____ Date of Birth _____ Gender _____

Your Physician's Name _____ Physician's address _____

Physician's phone number _____ Did your physician recommend colon hydrotherapy? Yes ☐ No ☐

Emergency Contact _____ Number _____

How did you find out about us?

☐ Practitioner (name & specialty) _____

☐ Internet/Website ☐ Other _____ Purpose of Visit/Main Complaint _____

A contradiction is an indication or symptom that makes it inadvisable to use a particular therapy. The following are contradictions for colon hydrotherapy. If any of these apply to you we are not able to treat you at this time. Once these contradictions have subsided, been eliminated, or you are under the supervision of a doctor (prescription needed) we will be able to treat you. Please check the appropriate boxes.

☐ Yes	☐ No	Abdominal Hernia
☐ Yes	☐ No	Abdominal Surgery
☐ Yes	☐ No	Acute Abdominal Pain
☐ Yes	☐ No	Acute Crohn's disease
☐ Yes	☐ No	Cancer of the Colon or GI(gastrointestinal tract)
☐ Yes	☐ No	Carcinoma of the Rectum
☐ Yes	☐ No	Cirrhosis
☐ Yes	☐ No	Congestive Heart Failure
☐ Yes	☐ No	Diverticulitis
☐ Yes	☐ No	Epilepsy or Psychosis
☐ Yes	☐ No	Fissures or Fistulas
☐ Yes	☐ No	General Debilitation
☐ Yes	☐ No	History of Seizures
☐ Yes	☐ No	Intestinal Perforation
☐ Yes	☐ No	Pregnancy

☐ Yes ☐ No Recent history of Colon or Rectal Surgery
☐ Yes ☐ No Recent history of GI Bleeding
☐ Yes ☐ No Recent history of Heart Attack
☐ Yes ☐ No Renal Insufficiency
☐ Yes ☐ No Severe Hemorrhoids
☐ Yes ☐ No Ulcerative Colitis
☐ Yes ☐ No Uncontrolled Hypertension
☐ Yes ☐ No Vascular Aneurysm

Health History: Do you currently have or have you had in the past, any of following : **C** for current **P** for past
General Symptoms:

☐ Allergies ☐ Dizziness ☐ Fatigue ☐ High or low blood pressure
☐ Anxiety ☐ Extreme weight loss ☐ Fever/chills ☐ Loss of sleep
☐ Convulsions ☐ Extreme weight gain ☐ Fissure ☐ Skin Condition
☐ Depression ☐ Fainting ☐ Headache ☐ Sweats

Gastro-Intestinal:

☐ Abdominal Gas/pain ☐ Constipation ☐ Hernia ☐ Rectal/GI hemorrhaging
☐ Appendicitis ☐ Crohn's ☐ Indigestion ☐ Urinary Tract Infections
☐ Bad Breath ☐ Diverticulitis ☐ Nausea ☐ Vomiting
☐ Belching ☐ Diarrhea ☐ Parasites/worms in stool
☐ Bloating ☐ Gallstones ☐ Polyps
☐ Blood in stool ☐ Hemorrhoids ☐ Poor appetite

Intestinal Procedures:
Please list any intestinal-related procedures you have had, along with the year it took place and your age at the time:

☐ Barium ☐ Colonoscopy ☐ Sigmoidoscopy ☐ Surgery ☐ Other

Other:

☐ AIDS/HIV ☐ Candida Albicans ☐ Failing Vision ☐ Nerve disorder
☐ Acid Reflux ☐ Chemical Toxicity ☐ Fibromyalgia ☐ Over weight
☐ Anal Discomfort ☐ Currently Pregnant ☐ mons. ☐ Frequent Urination ☐ Painful menstrual
☐ Anemia ☐ Diabetes ☐ Heart Condition ☐ PMS
☐ Anorexia ☐ Eczema ☐ Hepititis ☐ Poor Circulation
☐ Arthritis ☐ Edema ☐ Herpes ☐ Renal insufficiency

- [ ] Asthma
- [ ] Auto Immune Disorder
- [ ] Back Pain
- [ ] Bladder Problem
- [ ] Blood Clot/Vessel disorder
- [ ] Bulimia
- [ ] Cancer
- [ ] Enlarged Lymph Nodes
- [ ] Environmental Sensitivities
- [ ] Epstein Barr
- [ ] Excessive Hunger
- [ ] Excessive Menstrual Flow
- [ ] Eye Pain
- [ ] Hot Flashes
- [ ] Irregular Menstrual Cycle
- [ ] Intestinal Worms
- [ ] Kidney Stones
- [ ] Liver Disease
- [ ] Low Blood Sugar
- [ ] Mental Disorder
- [ ] Sinus Infection
- [ ] Spleen/pancreas
- [ ] Thyroid Problems
- [ ] Toxicity
- [ ] Tumor
- [ ] Ulcer
- [ ] Vaginal Discharge
- [ ] Yeast Infections

1. If your appointment is for Colon Hydrotherapy, is this your first Colon Hydrotherapy session? ☐ Yes ☐ No

   If not, where and when was your most recent visit? _____

2. Are you currently fasting? ☐ Yes ☐ No Are you currently cleansing? ☐ Yes ☐ No
   a. If yes type of fast or cleanse program:

   _____

3. Have you had surgery in the past? ☐ Yes ☐ No Please list history of surgical procedures/hospitalizations (include the year and your age at the time): ☐

4. Have you had any significant physical/emotional traumas or injuries? Please list _____

5. Do you use any of the following? How frequently? ☐ antibiotics _____ ☐ over-the-counter drugs _____ ☐ steroids _____ ☐ recreational drugs ☐ prescribed birth control _____ ☐ Herbs _____

☐ prescription drugs (please list) _____ _____

☐ anti-depressants (please list) _____ _____

☐ supplements (please list) _____ _____

7. Do you use an electronic medical device (i.e pacemaker)? ☐ Yes ☐ No

Diet: Using the following key, please indicate your dietary usage.

H=Heavy (5-7 times a week) L= Light (once a week or less) M=Moderate (2-4 times a week) N= Never

- [ ] Alcohol
- [ ] Antacids
- [ ] Baked goods
- [ ] Beans
- [ ] Caffeinated Coffee
- [ ] Caffeinated Tea
- [ ] Eggs
- [ ] Fast Foods
- [ ] Fatty Foods
- [ ] Fish
- [ ] Flax Fiber
- [ ] Nuts/Seeds
- [ ] Organic Foods
- [ ] Pasta
- [ ] Popcorn
- [ ] Poultry
- [ ] Smoothies
- [ ] Soda
- [ ] Soy
- [ ] Sugar
- [ ] Tobacco

☐ Carbonated Water ☐ Fruit ☐ Protein Shakes ☐ Wheat Products
☐ Cheese ☐ Green leafy vegetables ☐ Psyllium Fiber ☐ Wheat bread
☐ Chocolate ☐ Gum ☐ Red Meat/Animal Products ☐ Whole Grains
☐ Dairy Products ☐ Junk Food ☐ Salt ☐ Yogurt

Briefly describe your typical dietary intake for the following meals:

Breakfast

Lunch

Dinner

Snacks

How many bowel movements do you usually have? #Per Day ☐ # Per Week ☐

Do you strain to have a movement? ☐ Yes ☐ No Does the movement feel complete? ☐ Yes ☐ No

Please check applicable responses. The stool…

☐ Shows signs of mucus Usual Color

☐ Shows signs of blood Usual Shape

☐ Has a strong odor Usual Consistency

Do you exercise? ☐ Yes ☐ No How often? What type of exercise do you enjoy?

Height ☐ Weight ☐ Cigarette per day Alcohol per week

Meals per day Urine Color/Amt Sweat Day/Night

Sleep Sound/Hours Cup Coffee per day Mouth Taste/Smell/Dry

Family History Indicate relationship

☐ Cancer ☐ Diabetes ☐ Seizures ☐ High Blood Pressure

☐ HeartDisease ☐ Stroke ☐ Asthma ☐ Overweight

☐ Other

For Women

Menstruation

Age of first period ☐ Duration of period (range and latest period) ☐

# of Days between period ☐ Date of last period ☐

Pre-Menstrual Syndrome ☐

Vaginal Discharge

Quantity: Heavy ☐ Medium ☐ Light ☐ Clot ☐

Quality: Thick ☐ Medium ☐ Thin ☐ Color ☐

Breast

Lumps ☐ Yes ☐ No

☐

Pregnancy

Dates and # of Births ☐

# of Miscarriages ☐

Abortions ☐ IU's ☐ IFV's ☐

I have read and agree to the polices of THE PIPER CENTER *for Internal Wellness*

- Please be on time. If you are late, a shortened session will be charged at the full rate.
- We request payment in full at the time of your visit. We accept cash, Visa, MasterCard and personal checks.
- A referral from your primary health care provider or our supervising physician is required if you a condition or are following a prescribed treatment.
- We require 24 hours notice for all cancellations or postponements: otherwise you will be charged the full session. As a courtesy, we give clients a telephone reminder a day or two before an appointment.
- All series must be used within 1 year. No refunds are given after the 1 year expiration date.
- I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder. The therapist does not prescribe medical treatment or pharmaceuticals. It has been explained to me that colon therapy is not a cure or substitute for a medical examination, treatment or diagnosis. It is recommended that I see physician for any ailments that I might have. All information that I provided is correct to the best of my knowledge. If any health issues arise, I agree to inform my therapist.

Thank you for choosing THE PIPER CENTER *for Internal Wellness* for your alternative medical care. We look forward to working with you in your journey toward Health Inside and Out.

Client Signature _____Date:_____