Nardella

Creating Healthier Lives

COLON HYDROTHERAPY CLIENT INTAKE FORM

Personal Information

Name: _____ Age: _____
Address: _____
Date of Birth (dd/mm/yy) ___/____/___
City: _____ Province: _____ Postal Code: _____
Height: _____ Weight: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____
Occupation: _____
Referred by:_____ Reason for visit: _____
Physician's Name: _____ Phone Number: _____
Do you have extended health insurance? __ Yes __ No
If yes, please list provider: _____

I would like to be on the clinic's general mailing list to receive clinic information, such as subscriber specials and the clinic newsletter. Please circle YES/NO.

Check if you have currently or have had any of the following:

- o Arthritis
- o Blood Clots
- o Bursitis
- o Cancer
- o Diabetes
- o Epilepsy
- o Heart Trouble
- o T.B.
- o Yeast Infections
- o Vasectomy
- o High Blood Pressure
- o Infectious Disease
- o Varicose Veins
- o Migraine Headaches
- o Ulcers: _____
- o Crohn's
- o Colitis
- o Appendix Removed
- o Recent Surgery: _____ _____
- o Recent Accident: _____
- o Spinal Cord Injury
- o Alcoholism
- o Skin problems
- o Allergies:_____ _____
- o Mobility issues: _____ _____

Any other considerations or conditions? _____

Have you ever used any of the following in the last year?

- o Antacids
- o Stool Softeners
- o Laxatives
- o Diuretics
- o Steroids
- o Enemas
- o Anti-inflammatory Drugs
- o Antibiotics

Have you ever had Colon Hydrotherapy? ____ yes _____ no If yes, when and where?:
_____

List all medications and nutritional supplements you are currently taking:
_____
_____

Additional History for Colon Hydrotherapy Sessions

Your bowel movement (BM) frequency:
2 or more a day 1 per day 4 per week 2 or 3 per week less than 2 per week

Do you have to strain? ___ yes ___ no
Use laxatives? ___ yes ___ no
If yes, Brands(s): _____

Have you had any of the following?
Hemorrhoids When? _____
Rectal Bleeding When? _____
Barium Enema When? _____
Colonoscopy When? _____
Rectal Surgery When? _____
Abdominal Surgery When? _____
Colon Surgery When? _____

Check if you currently have the following:

- o Bad Breath
- o Coated Tongue
- o Swollen Ankles
- o Hungry between meals
- o Vomiting
- o Blood in Stool
- o Stress
- o Depression
- o Allergies
- o Indigestion
- o Gas
- o BM Difficult/Painful
- o Stool – Very foul odor
- o Burning stomach sensation
- o Burning/Itching anus
- o Asthma
- o Bronchitis
- o Greasy foods upset
- o Chronic fatigue
- o Hay Fever
- o Difficulty sleeping
- o Colitis
- o Constipation
- o Crohn's Disease
- o Ulcerative Colitis
- o Diverticulitis
- o Gallbladder Disease
- o Liver troubles
- o Abdominal Hernia
- o Diarrhea

Are you pregnant? Y/N Number of pregnancies: _____
Have had any complications with your current or prior pregnancies: Y/N
If yes, please describe:
_____
_____

Daily and Dietary Habits:

Alcohol:	Heavy	Moderate	Light	None
Coffee:	Heavy	Moderate	Light	None
Tobacco:	Heavy	Moderate	Light	None
Drugs:	Heavy	Moderate	Light	None
Exercise:	Heavy	Moderate	Light	None
Sleep:	Heavy	Moderate	Light	None
Appetite:	Heavy	Moderate	Light	None
Water:	Heavy	Moderate	Light	None

What do you usually eat :
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

Any other medical history/medications we should know about?
_____
_____

INFORMED CONSENT

I would like to take this opportunity to welcome you to the clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and supplemental therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.
Your practitioner will conduct a thorough case history, which may include a physical exam and specific laboratory testing as part of the treatment. Any practitioner you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

Statement of Acknowledgement

I, (printed name) _____ as a patient of this clinic, have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. As the clinic is an integrated health clinic, I recognize that all the practitioners that are working with me will have access to my file. I give my consent to have the Nardella Clinic contact me through e-mail, if necessary. I also recognize that even the gentlest of therapies potentially have their complications in certain physiological conditions, in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from venipuncture or acupuncture; and muscle strains and sprains.
I also confirm that I have the ability to accept or reject this care of my own free will and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so declaring.
I understand that, as a patient, **I am responsible for all costs incurred as a result of the decision including, but not limited to; the cost of all procedures involved in the treatment plan, the care provider's time, supplements, supplies and appointments missed or cancelled without sufficient notice (48 hours). I am aware that all telemedicine appointments will be charged to the credit card on file seven (7) days in advance of the appointment.** I am aware that treatments are not covered through Alberta Health Care and may not be covered under private health insurance.

Signature _____ Date _____

Please send intake form to info@nardellaclinic.com or fax to 403-282-0465.

We will review it to ensure you are an appropriate candidate, and give you a call to schedule an appointment.

Clinic Use Only:
Patient is suitable for treatment:

_____
Doctor's Signature