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APPOINTMENT DATE / /

Client Intake Form

Please fill out to the best of your ability, sign, date and bring with you to your first appointment.

Name ______ Birth date / / Age ______

Address ______
Street City State Zip

Phone: Home ( ) Work ( ) Mobile ( )

Occupation ______ E-mail ______

Where did you find out about Grace? ______

Have you had colon hydrotherapy before? ❑ Yes ❑ No If yes, when? ______

How many times a day or week do you have a bowel movement? ______

Have you ever been treated for a pathology of the colon? ❑ Yes ❑ No If yes, describe ______

Do you ever observe blood or mucus in your stool? ❑ Yes ❑ No

Do you ever experience diarrhea or constipation? ❑ Yes ❑ No If yes, please describe: ______

Do you have any immune system disorders? ❑ HIV+ ❑ AIDS ❑ Other ______

Do you have any family history of colon problems? ❑ Yes ❑ No If yes, please describe: ______

Do you have high blood pressure? ❑ Yes ❑ No Low blood pressure? ❑ Yes ❑ No

Please describe any surgery you have had? ______

Please list all medications: ______

What symptoms would you like to improve? ______

How do you feel today? ______

Please list the food you have eaten regularly in the last month: Is this your typical diet? ❑ Yes ❑ No

______

______

______

______

What snacks and foods do you crave? ______

Do you eat late at night? ❑ Yes ❑ No Please describe: ______

Is your diet high in fiber or bulk? What kinds? ______

Do you take laxatives? ❑ Yes ❑ No What kinds? ______

Do you take any dietary supplements or herbs? ❑ Yes ❑ No If so, please describe: ______

Do you desire nutritional and herbal guidance or support? ❑ Yes ❑ No

When was the last time you took antibiotics? ______ How much water do you drink a day? ______

Please check the following if you have had them in the last week:

Coffee ❑ Other Caffeine ❑ Alcohol ❑ Soda ❑ Sugar ❑ Tobacco ❑ Fast Foods ❑ Fried Food ❑

Do you sleep well? ❑ Yes ❑ No How many hours a night? ______

What are the stresses in your life? ______

What activities help you with stress reduction? ______

How often do you do these activities? ______ Do you exercise regularly? How? ______

Are you currently under a physician's care? ❑ Yes ❑ No If yes, why? ______

Prioritize the following list using the numbers 1–5 (1 being most important):

Work Family Self Care Meal Planning Spiritual Practice

Client Intake Checklist

CONTRAINDICATIONS

Some health conditions would contraindicate colon hydrotherapy. In order to determine whether any of these relate to you, please check YES or NO for the following. If it was in the past, please write P and year.

Are you pregnant? If so, how many months?

Colitis ❑ Yes ❑ No

Ulcerative Colitis ❑ Yes ❑ No

Chrohn's Disease ❑ Yes ❑ No

Acute Fistula ❑ Yes ❑ No

Intestinal Ulcers ❑ Yes ❑ No

Aneurysm ❑ Yes ❑ No

Hypertension ❑ Yes ❑ No If yes, is it controlled?

Gastrointestinal Hemorrhage ❑ Yes ❑ No

Gastrointestinal Perforation ❑ Yes ❑ No

Cirrhosis of the Liver ❑ Yes ❑ No

Abdominal Hernia ❑ Yes ❑ No

Acute Anemia ❑ Yes ❑ No

Abdominal Radiation ❑ Yes ❑ No

Irritable Bowel Syndrome ❑ Yes ❑ No

Spastic Colon ❑ Yes ❑ No

Rectal Fistula ❑ Yes ❑ No

Hyper/Hypothermia ❑ Yes ❑ No

Mucous Colitis ❑ Yes ❑ No

Bleeding Colitis ❑ Yes ❑ No

Acute Fecal Impaction Parasitic Infections ❑ Yes ❑ No

Diverticulosis ❑ Yes ❑ No

Diverticulitis ❑ Yes ❑ No

Severe Hemorrhoids ❑ Yes ❑ No

What was your last blood pressure reading?

Rectal Fissure ❑ Yes ❑ No

Congestive Heart Failure ❑ Yes ❑ No

Kidney Insufficiency or Failure ❑ Yes ❑ No

Recent Colon or Rectal Surgery ❑ Yes ❑ No

Recent Abdominal Liposuction ❑ Yes ❑ No

Colon Cancer ❑ Yes ❑ No

Chronic Abdominal Pain ❑ Yes ❑ No

Acute Inflammatory Pathology of the Colon ❑ Yes ❑ No

Every therapy, service and product described or presented by Grace Kingsley is NOT a cure for any disease, ailment or health condition. NO MEDICAL CLAIMS are expressed/implied, either directly or indirectly. I do not diagnose, treat or prescribe. I,__________________________, agree that the above information is accurate to the best of my knowledge. I give Grace Kingsley permission to provide colon hydrotherapy. I am aware of and do not have any of the above listed contraindications. I am aware of my 9th Amendment Rights to practice alternative health modalities, and agree that I am responsible for my health and the services received here.

____

Legible Printed Name of Client

____________________________________ ____________________________________

Signature of Client — Date of Signature

We appreciate your patience and honesty in filling out this form