Health Intake Form www.miamicolontherapy.com Tel: 305.834.2032

Name Date

Address City ST ZIP

Telephone (circle preferred contact) Home Cell

Email Referred By:

Height Weight Birthdate

Are you currently under a medical doctor's care? Yes/NO Explain

Doctor's name Telephone

List all surgeries/dates

List all medications (including over the counter) & supplements

The following conditions are *contraindications* for colon hydrotherapy unless under the supervision of a doctor.
Have you ever been diagnosed with any of the following? If so, please explain in writing on the back of this form.

___Aneurysm/Blood clot	**___Colitis**	**___Cardiac Disease**	**___Colorectal Cancer**
___Cirrhosis of Liver	**___Epilepsy**	**___Seizure Disorder**	**___Kidney disease/dialysis**
___Bleeding Hemorrhoids	**___Fissure**	**___Prostatitis**	**___Recent Abdominal Surgery i.e. gall**
___GI Hemorrhage	**___Crohn's**	**___Diverticulitis**	**bladder/appendix/prostate removal,**
___Abdominal Hernia	**___Fistula**	**___Rectocele**	**C-Section, hysterectomy, etc.**
Uncontrolled blood pressure		**ARE YOU PREGNANT?**	**If so, no colon hydrotherapy.**

Please put an "X" beside anything that is currently a health challenge. Put a "P" beside a past problem.

___ acid reflux	**___cancer**	**___infections**
___acne	**___celiac disease**	**___insomnia**
___allergies	**___constipation**	**___irritability**
___anemia	**___cysts/tumors**	**___menstrual difficulties**
___anorexia/bulimia	**___diabetes**	**___mental illness**
___antibiotics	**___diarrhea**	**___mood disorder**
___arthritis	**___dizziness**	**___multiple sensitivities**
___asthma	**___fatigue**	**___multiple sclerosis**
___autism	**___flatulence/gas**	**___neurological symptoms**
___autoimmune issue	**___headaches**	**___prostatitis**
___backache upper/lower ?	**___hemorrhoids**	**___sinus problems**
___belching	**___hepatitis TYPE?**	**___swollen glands**
___birth control pills/ HRT	**___herpes I or II ?**	**___ulcers**
___brain fog	**___hiatal hernia**	**___vision/hearing impaired**
___breast implants WHEN?	**___hair loss/growth**	**___water retention**

How often do you have a bowel movement? What time of day?

Are they spontaneous? Only after eating? Requires straining? Effortless?

Do you have hemorrhoids or other rectal problems?

How often do you use a laxative? Herbal laxative? Stool softener? Suppositories?

Enemas? Have you ever had rectal bleeding? If yes, when?

Mark "Y" for yes and "N" for no. **If yes, list amount and frequency.**

___coffee_____ diet programs_____

___tea_____ vegetarian/vegan_____

___carbonated drinks_____ exercise (type and frequency)_____

___alcohol_____ hours sleeping_____

___tobacco_____ stress management (type)_____

___sugar/salt cravings_____ dairy products_____

___plain water intake per day_____ source of water _____

HOW MANY MERCURY FILLINGS DO YOU HAVE IN YOUR TEETH?_____ HOW MANY ROOT CANALS?_____
WHEN? _____
What do you hope to achieve from this appointment?_____

I acknowledge that Alicia J. Earles (License #MA78712) is FL licensed to perform massage/colonics.
She is not a medical provider and does not diagnose nor prescribe. I am voluntarily requesting services.

SIGNATURE_____ Full charge without 48-hour notice to change an appointment. Thanks!