Devine Health Intake Form devinehealth.ulla@gmail.com | (250) 352 - 6419

Name:	Date:
Address:	Phones: Home/Work/Cell
City, Postal Code:	Single Married Divorced Widowed
Email:	# of children: Ages:
Birth date: Age:	Name of Physician:
Occupation:	Referred by:
Emergency Contact Person:	Emergency Contact Phone Number:

What health conditions are you currently being treated for and by whom? _____

_____

Contraindications for Colon Hydrotherapy

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, you may not be eligible for colon hydrotherapy sessions at the present time.** If you have some of these contraindications, you may still be eligible to receive colon hydrotherapy once they have subsided or been eliminated.

(Circle all that apply to you)

Abdominal Hernia	Diverticulitis	Recent Colon or Rectal Bleeding
Abdominal Surgery	Fissures or Fistulas	Renal Insufficiency
Acute Abdominal Pain	History of Seizures	Severe Hemorrhoids
Acute Crohn's Disease	Intestinal Perforations	Ulcerative Colitis
Carcinoma of the Rectum	Pregnancy	Uncontrolled Hypertension
Congestive Heart Failure	Cancer of the Colon or Gastro Intestinal (GI) Tract	

Bowel Movements # movements/day _____

(Circle all that apply):

firm runny incomplete explosive thin thick well-formed long (6 inches +)

What do you hope to achieve from this session? _____

_____

Disclaimer: Colon Hydrotherapy is not intended to replace the relationship with your primary health care providers and my consultation is not intended as medical advice. The sessions are intended as a sharing of knowledge and information from my education, training, and experience.

As a Colon Hydrotherapist, I encourage you to be open to new information on the effectiveness of colon hydrotherapy and the fundamental role of diet, exercise, stress management, emotional and mental work. I encourage you to make your own health care decisions based upon your research and in partnership with your primary health care providers, ND, MD or otherwise. The information and services provided is not used to prescribe, recommend, diagnose or treat a health problem or disease and is not a substitute for medical care.

I understand and acknowledge that, in undertaking colon hydrotherapy with Ulla Devine, I am doing so at my own risk. It is with this understanding that I voluntarily sign this release and waiver.

Signed: _____ Date: _____

This part is optional; however, it will give me a better idea on how to assist you with your healing

Have you experienced or do you experience any of the following: use P for PAST symptoms

Arthritis	Fatigue (low energy)	Kidney/Bladder Infection
Back and Neck aches, injuries and pain	Headaches	Parasites
Bad Breath	Heavy Mucus Production	Sinus Congestion
Brain Fog (loss of concentration)	Haemorrhoids	Skin Disorders
Candidiasis (yeast overgrowth)	Indigestion (heart burn/acid reflux)	Spastic Colon
Depressions	Intestinal Gas (Bloating)	Weight Issues
Diarrhea	Irritable Bowel Syndrome (IBS)	Other

Please describe your present and historical use of the following:

Coffee	Birth Control
Pharmaceutical and/or recreational drugs	Chemical Laxatives
Antibiotics	Tobacco

Are you pregnant, or is there any possibility of being pregnant? Yes / No **Are you breastfeeding?** Yes / No

Have you ever had abdominal surgery (including C-sections)? Yes / No **If so, what type, how many, when?**

List any known allergies:

Do you have pain in any areas of your abdomen or bowel? Yes / No **If yes give details:**

Are there any traumatic events (surgeries, drug reactions, life trauma, and major illnesses) that you feel might have caused, or contributed to your health problems?

Are you presently or have you ever been exposed to any toxic chemical, solvents, tobacco smoke, or any other possible toxins at home and at work?

Vaccine history: Childhood vaccines _____

Regular flu shots _____

Reactions to vaccines _____

Do you have any silver amalgam fillings? Yes / No **How many?** _____ **When removed?** _____

Please circle/list all medications and supplements you are taking:

Fiber (psyllium / flax / other _____) Probiotics Enzymes Vitamins Other:

_____

Circle all that apply to your diet:

Raw foods Eggs Dairy Meat Flour products/Bread Sugar Artificial sweeteners

Soy products Fried foods Fast foods Cookies/Sweets Organically grown fruits and vegetables

Sensitivities to the following foods: _____

Past dietary habits (including childhood diet): _____

Estimate your DAILY liquid intake in cups for each:

Water	Soda	Herbal Tea	Alcohol
Juice	Coffee	Black Tea	Other

Eating Behaviors: (circle all that apply) overeating binging anorexia bulimia late night eating

Eating when: in pain fatigued constipated emotionally upset not hungry depressed

Do you eat slowly and chew well? _____

Are you able to eat/drink what you intuitively feel is right for you? _____

Describe your exercise habits:

_____

Describe other types of bodywork you currently receive or have received in the past? What has worked for you?

_____

Rate the stress level in your life on a scale from 1-10 (10 being the highest): _____

What is the main reason for your stress? _____

What steps are you taking to decrease your stress levels? _____

How do you feel about the state of your health? What about it do you want to change?

_____

Rate your level of commitment to getting healthy on a scale from 1-10 (10 being the highest): _____

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

Initals: _____ **Date:** _____