POLO
HEALTH + LONGEVITY CENTRE

Intake Form for COLON HYDROTHERAPY

Name: _____ Date:_____

Phone: (h)_____(cell)_____(best)_____E-mail:_____

Address:_____City:_____Prov:_____Postal Code:_____

Age:_____ D.O.B:_____ Occupation:_____

Have you had colonics before? Y / N Reason for having colonics:_____

Have you ever made any significant dietary changes?_____

HEALTH CONDITIONS

Any Colon challenges? (please circle) Constipation, Diarrhea, Abdominal Pain, Bloating, Gas, Hemorrhoid

How often do you have a bowel movement?_____ Stress Level (1-10):_____

Please list any Medications, Remedies, Supplements you are taking:_____

_____

Food allergies or restrictions:_____

Diagnosed health conditions:_____

Do you have, or are you a carrier of any infectious disease?_____If so, what?_____

Contraindications to Colon Hydrotherapy (please circle Y or N)

Abdominal Hernia	Y / N	Dialysis Patients	Y / N
Abdominal Surgery	Y / N	Diverticulitis	Y / N
Abnormal Distension	Y / N	Fissures & Fistulas	Y / N
Acute Liver Failure	Y / N	Hemorrhaging	Y / N
Anemia	Y / N	Hemorrhoidectomy	Y / N
Aneurism – All types	Y / N	Hernia	Y / N
Carcinoma of the Colon	Y / N	Intestinal Perforation	Y / N
Cardiac Condition	Y / N	Lupus	Y / N
Cirrhosis	Y / N	Pregnancy (1^{st} & 3^{rd} trimester) get Rx	Y / N
Crohns Disease	Y / N	Rectal/Colon Surgery	Y / N
Colitis	Y / N	Renal Insufficiencies	Y / N

Signature:_____ Date:_____