

## Betsy Exton, Certified Colon Hydrotherapist

### Colon Hydrotherapy Intake Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Referred by: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Are you currently under a physician's care? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ Allergies? \_\_\_\_\_

Surgeries? \_\_\_\_\_

List all medication (including over the counter): \_\_\_\_\_

Please put an "X" beside any current occurrences. Put an "I" beside any past occurrences.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Constipation    | <input type="checkbox"/> Allergies        | <input type="checkbox"/> Swollen Glands          |
| <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Parasites        | <input type="checkbox"/> Gallbladder Problems    |
| <input type="checkbox"/> Hemorrhoids     | <input type="checkbox"/> Yeast Infections | <input type="checkbox"/> Impaired Hearing        |
| <input type="checkbox"/> Indigestion     | <input type="checkbox"/> Insomnia         | <input type="checkbox"/> Cysts/Tumors            |
| <input type="checkbox"/> Belching        | <input type="checkbox"/> Anemia           | <input type="checkbox"/> Infections              |
| <input type="checkbox"/> Flatulence/gas  | <input type="checkbox"/> Irritability     | <input type="checkbox"/> Antibiotic Use          |
| <input type="checkbox"/> Ulcers          | <input type="checkbox"/> Hypoglycemia     | <input type="checkbox"/> Birth Control Use       |
| <input type="checkbox"/> Colitis         | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Prostate Problems       |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Sinus Problems   | <input type="checkbox"/> Urination Problems      |
| <input type="checkbox"/> Headaches       | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Blood Pressure Problems |
| <input type="checkbox"/> Fatigue         | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Breast Implants         |
| <input type="checkbox"/> Backaches       | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Pregnancy               |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Parkinson's      | <input type="checkbox"/> Psychological Disorders |
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Water Retention         |
| <input type="checkbox"/> Acid Reflux     | <input type="checkbox"/> Hiatal Hernia    | <input type="checkbox"/> Difficult Menstruation  |

**Bowel Health:**

How often do you have a bowel movement? Per day? \_\_\_\_\_ Per week? \_\_\_\_\_

Are they spontaneous? \_\_\_\_\_ After eating? \_\_\_\_\_ Requires Straining? \_\_\_\_\_ Effortless? \_\_\_\_\_

Do you have hemorrhoids or other rectal problems? \_\_\_\_\_

Do you use (circle all that apply): Laxatives, herbal laxatives, stool softeners, suppositories, enemas?

Have you ever experienced rectal bleeding? \_\_\_\_\_ If yes, when? \_\_\_\_\_

List all current supplements: \_\_\_\_\_

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

- |                 |                           |                          |
|-----------------|---------------------------|--------------------------|
| — Coffee _____  | — Tobacco _____           | — Daily Exercise _____   |
| — Tea _____     | — Sugar/Salt _____        | — Dairy _____            |
| — Alcohol _____ | — Diets _____             | — Sleep (hrs) _____      |
| — Soda _____    | — Stress Management _____ | — Vegetarian/Vegan _____ |

What is your daily consumption of plain 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? \_\_\_\_\_

**Policies:**

To accommodate my client's schedules I do require a 24-hour cancellation notice for an appointment, emergencies expected.

For your future knowledge- If you cancel or reschedule your appointment within the 24-hour period of your appointment you will be charged a \$40.00 cancellation fee. I enforce this policy to honor all of my clients, as we all have busy schedules. Our office needs at least 24 hours to schedule another client in your designated appointment time. If not given that time, then someone else may suffer needlessly.

As a busy clinic, each of our staff members does their best to accommodate every client. We appreciate your cooperation and consideration.

**Package Information:**

- 1 session- \$80.00
- 3 sessions- \$215.00 (\$25.00 savings)
- 6 sessions- \$400.00 (\$80.00 savings)
- 10 sessions- \$600.00 (\$200.00 savings)

Yours in Health,  
Betsy Exton, Colon Hydrotherapist

------(Tear Here)-----

I, \_\_\_\_\_, understand and agree to the cancellation policy for Betsy Exton.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_