YELLOWSTONE NATUROPATHIC CLINIC
720 N 30th St Billings, MT 59101 406-259-5096 Fax: 406-545-0044

DETOX/COLONIC SCREENING FORM

Name ______________________ Age ___ DOB __________ Blood type _____

Address ______________________ City ______________ State ___ Zip ________

Phone (home) ________________ (work) ________________ Daytime or eve? ____

Last physician or healthcare practitioner seen? ________________ When? ___________

When was your last blood test?___________ Which tests? ____________________

Your Current Health Problems

List in order of importance other health problems troubling you:

1)______________________________ Length of time______________________

2)______________________________ Length of time______________________

3)______________________________ Length of time______________________

Have you ever done a detox? ________ How many? ____ What type? ________________

Have you ever had a colonic? _______

Your Health History

The general state of your health is? excellent good average fair poor

Previous surgeries and hospitalizations (including dates) ________________________

____

Please indicate which of the following are current or past medical problems (include the year).

	now	past		now	past		now	past
Allergies			Anemia			Asthma		
Cancer			Canker Sores			HIV		
Chronic Infections			Crohn's Disease or Ulcerative Colitis			Diabetes		
Ear Infections			Eczema			Enlarged Prostate		
Epilepsy			Thyroid Problems			Headaches		
Heartburn			Heart Disease			Heart Palpitations		
Hemorrhoids			Hepatitis			Herpes		
Sexually Transmitted Infections			High Blood Pressure			Iritable Bowel Syndrome		
Mononucleosis			Numbness			Osteoporosis		
Pancreatitis			Polyps			Stomach Ulcer		
Tonsillitis			Weight Problems			Other:		

Continued on Back →

Are you allergic to any drugs, herbs, foods, animals or other? _____Which one(s)? __________
____

Family History

Please list ages, health problems and if deceased, the cause of death (only include blood relatives):

	Living(L) or Deceased(D)	Health Problems	Age	Cause of death
Mother				
Father				
Brothers				
Sisters				
Grandparents				
Mother's mom				
Mother's dad				
Father's mom				
Father's dad				

Diet

Are you following any specific diet or dietary restrictions? ______________________________

Exercise

Activity	Days per week	Minutes per session	Year & month started

Do you have any difficulty perspiring? _______ Do you perspire lightly, moderately or heavily when exercising? _________ Do you perspire at other times other than exercise? ___________ Is there any strong odor to your perspiration? ________

Kidneys and bladder

How many times per day do you urinate? ____ Do you have any burning sensation during or after urination? _______ Any dark yellow, brown, or orange color to your urine? ____________
If so, please describe____
Any difficulty starting or stopping your urine stream? ______ Incontinence? _________
Have you had any recurrent bladder infections? _______ How often? ______________________
What treatments were used? ____
How much water do you drink in a typical day (ounces /glasses/ cups)? ___________

This visit is solely for the purpose of screening for the above procedure only. *It is limited in scope and not a replacement for a personal physician.* A report will be sent to your personal physician <u>if requested</u> (name) ____

Patient Signature ____ Date _________________

Physician Signature ____ Date _______________

YELLOWSTONE NATUROPATHIC CLINIC
720 N 30th St Billings, MT 59101 406-259-5096 Fax: 406-545-0044

Colon Hydrotherapy Consent

Print Patient Name:______________________________________ **DOB:**__________________

What is a colonic irrigation or colon hydrotherapy?
Colon Hydrotherapy or colonic irrigation has been used for centuries to maintain health, as a component of fasting/cleansing/detox programs. A colonic irrigation, using the Wood Gravitational System, is an internal bath that helps cleanse the colon of toxins, gas and accumulated fecal matter. Unlike an enema, it does not require the retention of water. With minimal discomfort and internal pressure there is a steady gentle flow in and out of the colon. If indicated, a gentle abdominal massage is utilized to stimulate the colon to recover its natural shape, tone and peristaltic wave action.

How is colon hydrotherapy administered?
A patient receiving a colonic lies on a table 18 inches below the temperature-controlled input water holding tank. ***During the therapy, the person is dressed in an exam gown and is well covered for modesty and warmth.*** *Warm socks, an eye pillow and a warm pack for the abdomen are also provided for comfort. Relaxing music is playing in the background.* A sterile speculum is carefully inserted into the rectum. Under constant and direct control of the therapist, a gentle stream of water flows into the colon, and then out through the evacuation tube. Impacted feces and mucous flow out of the evacuation tube along with the expelled water. As the water flows out of the colon, the practitioner gently massages the abdomen as needed to help the colon release its contents.

Are there side effects of colonics?
There may be nausea and mild cramping during or after the treatment. Occasionally some people experience flu-like symptoms, such as headaches. Toxins that have been lying dormant in the colon are now being flushed out and a small amount may be reabsorbed into the body's system. This healing crisis passes quickly and the person realizes a feeling of well-being with further treatments. *In conjunction with a Detox Program, these symptoms are minimized and may be relieved by a colonic.* **It is important to be screened by a doctor for any contraindications to treatment which can lead to problems if colon hydrotherapy is performed.**

Contraindications - Please mark any that are current:

___ NONE
___ Severe anemia
___ Ulcerative colitis
___ Diverticulitis
___ Fissures/fistulas
___ Renal insufficiency
___ Epilepsy or History of seizures
___ Carcinoma of the colon or rectum
___ Aneurysm
___ GI hemorrhage/perforation
___ Crohn's disease
___ Hepatitis A, B, C
___ Recent colonoscopy
___ Gastrointestinal infection
___ Miscarriage (less than 4 months post-op)
___ Severe cardiac disease
___ HIV/AIDS
___ Kidney dialysis
___ Cirrhosis
___ Vomiting at present time
___ Immunocompromised
___ Pregnant/Breast Feeding
___ Abortion (less than 6 months)
___ Congestive heart failure of organic valve disease

→*Please note any of the following conditions (to be discussed with the hydrotherapist and cleared by your physician.)*

___ Anticoagulant medication
___ Abdominal hernia / inguinal hernia
___ Severe hemorrhoids
___ Rectal bleeding
___ Colon or abdominal surgery
___ Severely obese (BMI >45)

Your signature below means:

a. You read and understand the information provided on this form and agree to the foregoing.
b. You received all the information and explanation you desire concerning the procedure.
c. You authorize and consent to the performance of the procedure(s).

Patient/Representative: ____________________ ________________________
Print Name Signature

Date: ______________ If signed by a representative, indicate relationship ________________

Witness: ____________________________________ Date: ______________

Treating Therapist:____________________________ Date:________________