150 East 55th Street, 6th Floor / New York, NY 10022 / Phone 212-832-6800/ Fax 212-832-6138

New Client In-take Form

Personal History

Name: _____ Date of Birth: ___/___/____ Age: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code_____

E-mail: _____ Cell #: _____ Home #:_____

Work #: _____ Occupation: _____ How did you hear about us? _____

Emergency Contact: _____ Contact Number: _____

Colon Hydrotherapy/Colonics, like any health treatment, have some contraindications that may deem it inadvisable to use this therapy. The following are contraindications for colon hydrotherapy. If you have any of these contraindications, it is at your discretion or if you are under the order, guidance and supervision of a qualified physician working with Provence Wellness Center. You may still be eligible to receive colon hydrotherapy once these conditions have subsided or been eliminated. Provence Wellness Center does not claim to diagnose any such condition, and is not liable for any such ailments.

Please circle any conditions, listed below, that you may have or have had. If you have a prescription from a doctor showing supervision over services here for a particular condition, please so indicate.

Cancer of the colon or GI tract
Acute abdominal pain
Recent history of GI or rectal bleeding
Congestive Heart Failure
Uncontrolled hypertension
History of Seizures
Carcinoma of the rectum
Abdominal surgery
Intestinal perforation
Abdominal hernia
Recent colon or rectal surgery
Diverticulitis
Recent heart attack
General debilitation
Vascular aneurism
Renal insufficiency
Epilepsy or psychoses
Severe hemorrhoids
Cirrhosis
Fissures or fistula
Pregnancy
Ulcerative colitis
Acute Crohn's disease
Rectal or abdominal tumors

****Please initial that you have answered the above question to the best of your ability. _____****

Have you ever had a colonic? _____ If so, how many? _____ When? _____

Other cleansing experiences? _____

Main problems or concerns for this appointment? _____

_____

Please list all allergies (including food, drugs and environmental): _____

_____

Please check any of the following that you have been experiencing within the past year.

General

Fatigue	Insomnia	Weight loss	Dizziness
Fainting	Seizures	Depression	Headaches/Migraines
Enlarged thyroid	Blurred vision	Bad breath	Brain fog

Gastro-Intestinal

Colitis	Constipation	Crohn's Disease	Ulcerative Colitis
Diverticulitis	Liver trouble	Fissures/Fistulas	Gall bladder disease
Cirrhosis	Rectal bleeding	Blood in vomit	Family history of colon cancer
Cancer	Hemorrhoids	Parasites	Diarrhea
Spastic colon	IBS	Indigestion	Intestinal gas
Mucous	Candidiasis		

Skin

Eczema	Psoriasis	Rash	Itching
Dryness	Bruise easily	Dullness in skin	

Respiratory

Chronic cough	Blood in vomit	Emphysema	Bronchitis
Asthma	Sinus	Shortness of breath	

Cardiovascular

Hard arteries	Irregular heart beat	Angina	High blood pressure
Angle swelling	Rapid heart beat	Poor circulation	Congestive heart failure

Muscle & Joint

Arthritis	Bursitis	Neck pain	Lower back pain
Swollen joints	Other pain(s)		

OB/Gyn

Painful menses	Vaginal discharge	Breast pain	Pregnant

Urinary

Kidney failure	Prostate trouble	Painful urination	Kidney infection
Kidney stone			

Bowel Related Information

How many bowel movements a day or week (on average) do you have? _____

Check all that apply

Stool Consistency	Stool Size	Stool Elimination
Formed	Small	Complete
Unformed	Medium	Incomplete
Hard	Large	Explosive
Runny	Pencil thin or flat	Strained
Other	Other	Other

Diet and Lifestyle Information

Do you buy organically grown fruits _____ vegetables _____ dairy _____ meat _____ ?

How often do you cook at home? _____

How much water do you drink in a day? _____

Describe your diet:

Intake	Daily	Weekly	Monthly	Never
Flour products/Bread				
Fruits				
Vegetables			Other	
Raw foods				
Whole grains				
Red meat				
Eggs				
Dairy				
Artificial sweeteners				
Sugar				
Soy Products				
Fried Foods				
Fast Food				
Caffeine				
Soda				
Juice				
Alcohol				
Tobacco				
Prescription drugs				
Recreational drugs				
Laxatives				
Other				

Rate the stress in your life on a scale of 1 (least) – 10 (most) and describe: _____

_____

Do you exercise? If yes, how much and how often? _____

If no, why? _____

Do you feel like you get restful sleep? If so, how often? _____

Do you binge eat? If so, how often? _____

Cleansing Goals:

How do you feel about the state of your health? What/How would you like that to change?

_____

Do you have interest in a specific type of cleanse? _____

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We take your journey to wellness seriously. To assist you in achieving and surpassing your health goal, we do selectively follow up with clients after their visit.

Please indicate & initial here if you prefer not to receive follow up communications. _____

At Provence Wellness Center, we are wholly focused on an integrative approach to attaining and maintaining optimum health. Thus we also offer the following services:

Lymphatic Drainage Therapy
Holistic Facial Treatment
Organic Sugar Scrub
Reflexology
Customized Therapeutic Massage
Detoxifying Body Mud Wrap
Reiki
Infrared Sauna

Signature and Authorization
I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder and does not prescribe medical treatment or pharmaceuticals. I understand that colon hydrotherapy is not a cure, substitute for medical examination or diagnosis and that it is recommended that I consult my physician for any ailments that I might have. I agree that the therapist is helping me with natural hygiene at my request, and is not diagnosing, nor treating disease, nor practicing any form of medicine.

Information provided by Provence Wellness Center and its website has not be evaluated by the FDA. Reliance on information and service provided by Provence Wellness Center is solely at my own risk.

Provence Wellness Center disclaims any liability for any alleged injury sustained as a result of my visit.

I agree to pay in full at the time of the service for all treatments rendered. If I fail to cancel, reschedule or miss an appointment without notifying Provence Wellness Center 24-hours in advance, I agree to pay the full, non-discounted price of the treatment or allow for the redemption of Gift Certificates or account credit.

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

Signed _____ **Date** _____

Thank you for choosing Provence Wellness Center for your detoxification and health maintenance needs. We look forward to joining you on your journey to optimum health and well-being!

PROVENCE
WELLNESS CENTER

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www.provencewellness.com