CLEAR LIVING CLINIC CONFIDENTIAL INTAKE FORM

600 Sherbourne St., Suite 610 Toronto ON M4X 1W4 Tel 416-962-1973

DATE : ______________________________ NAME:____
HOW DID YOU FIND US? PLEASE CIRCLE ONE. GOOGLE/YELP/FRIEND or FAMILY/OTHER _____
NAME OF A REFERRAL (IF APPLICABLE): __________________________
DATE OF BIRTH: ____________________________
ADDRESS: ____________________________ CITY: _________________ POSTAL CODE:_________
PHONE: HOME : ____________________________ CELL: __________________________
E-MAIL: ______________________________________ OCCUPATION: ________________________

What symptoms or health concerns brings you to this appointment?

____

____

Please list any disease(s) or illness you have been diagnosed with:

____

Have you been hospitalized, or had surgery, or any organ(s) removed?

____

Contraindications for Colon Hydrotherapy, please mark all that apply with Y or N

Fissures or Fistula ___ Colon Cancer ____ Surgery ____ Hernia ____ Renal Failure ____ Liver Cirrhosis _____
Severe Hemorrhoids _____ Heart Failure ____ Are you pregnant? ____ Intestinal perforation _____
Diverticulitis ____ Crohn's ____ Ulcerative Colitis _____

Other disorders please mark with a Y or N: Appendix ____ Kidney Stones ____ Gallstones ___ Ulcer____
IBS ___ Candida ___ Diabetes ____ Polyps ____

Are you presently under a doctor's care? (Yes/No) If Yes, for what?

____

Do you experience digestive difficulties? (please Circle all those that apply)

Constipation, Gas, Bloating, Heartburn, Burping, Diarrhea, Abdominal pain, Fatigue, Headaches, Joint Pain

List any medications you are currently taking (prescription and over the counter):

____

List any supplements you are taking: ____

Emotions: What is your level of stress? Minimal _____ Average _____ Considerable ______
How many hours of sleep do you get at night? _______ Do you wake feeling rested? _______
Do you experience (Y or N): Mood Swings? _____ Depression? _____ Anxiety? _____ PMS? ______

Chemicals: (Y or N)
Are/Were you a smoker? ______ How many daily? ______ For how long? _____ If you quit, when? ___________
Drink tap water? ______ Eat organic fruits and vegetables? _______ Use an air purifier? _______

Have you travelled in the last year? ______ Did you get ill on the trip or upon returning home? _____________

Have you done a parasite cleanse? __________ When? ________

Do you use laxatives, and if yes what kind and how often? ________________ **Do you use antiacids**? _______
Are you on a cleanse or special diet? _________________________ **Are you a vegetarian/vegan?** ___________

How much of the following do you drink daily? Water ____ (L) Coffee ______ Juice ____ Pop ______
Alcohol ______ Beer _____ Wine _______ Black tea _____ Herbal tea ______

How many times in a week do you eat the following foods? Meat (beef,chicken,eggs,fish) _______ Nuts _____
Fruits _____ Vegetables (raw) _______ (cooked) ______ Dairy _____ Baked goods ______ Beans _________
White flour products (rice, bread etc) ________ Whole grains (quinoa, brown rice, oats, barley) ________

Do you have any food allergies? ____
What foods do you crave? ____

In an average day, what do you eat at each meal?
Breakfast ____
Lunch ____
Dinner ____

How often do you have bowel movement ? (Please circle all that apply)

* **Frequency**: Daily 1x - 2x -3x, Every 2-3days, Weekly, Once/wk or less
* **Consistenc**y: Hard, Dry, Firm, Soft, Loose/Watery
* **Contents**: Mucous (white/yellow), Blood, Bits of food
* **Any comments**: ____

I, the undersigned, hereby acknowledge that the personnel at Clear Living Clinic are not prescribing (ordering for use as medicine) for me at any time, and I will not hold them accountable for such. Any recommendations I receive are not intended as primary therapy for any symptoms or disease, but as a means of enhancing of my diet. I understand that Colon Hydrotherapy is a professional service which may provide information related to nutritional requirements, however this service is not a tool for the prevention, assessment or diagnosis, or treatment of any particular illness or disease. The services I receive are initiated at my own request for reasons personal to me.
** **I understand that all sessions and series I purchase are fully non-refundable. I understand that the package expires after 12 months ** If I miss or cancel my appointment without giving 12 hours notice I agree to be charged a $60 late cancellation fee by Clear Living Clinic to the valid credit card I have provided. I also agree my appointment will be rescheduled if I'm late for over 15 min for my appointment and the same cancellation policy as above applies.**

Client signature ______________________________ Date: ________________________