



# HOLISTIC QUESTIONNAIRE

**All information is confidential**

TODAY'S DATE \_\_\_\_\_

NAME: \_\_\_\_\_ MALE/FEMALE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ DO YOU HAVE CHILDREN? \_\_\_\_\_ IF SO, HOW MANY? \_\_\_\_\_

IF YOU ARE A WOMAN, ARE YOU CURRENTLY PREGNANT? \_\_\_\_\_ IF SO, WHAT TRIMESTER? \_\_\_\_\_

HAVE YOU EVER TRAVELED ABROAD?  YES  NO

## HOW DID YOU HEAR ABOUT LIFETIME HEALTH AND CONSULTING?

- INTERNET/WEBSITE SEARCH  PRACTITIONER (NAME SPECIALTY) \_\_\_\_\_  
 SPIRIT OF CHANGE ADVERTISEMENT  LHC CLIENT (NAME) \_\_\_\_\_  
 EARTH STAR ADVERTISEMENT  FRIEND (NAME) \_\_\_\_\_  
 OTHER \_\_\_\_\_

HAVE YOU EVER HAD A COLONIC? \_\_\_\_\_ IF SO, WHEN?: \_\_\_\_\_

MARK YOUR EXPERIENCE WITH COLON CLEANSING (CHECK ALL THAT APPLY):

- LAXATIVE  FASTING  JUICING  HERBS  NONE  OTHER \_\_\_\_\_

WHAT IS YOUR REASON FOR SEEKING COLON CLEANSING? \_\_\_\_\_

ARE YOU NOW UNDER PHYSICIAN CARE FOR A SPECIFIC AILMENT? \_\_\_\_\_ PLEASE EXPLAIN: \_\_\_\_\_

PHYSICIAN NAME: \_\_\_\_\_ PHYSICIAN PHONE: \_\_\_\_\_

LIST HOSPITALIZATIONS/SURGERIES WITHIN THE PAST 3 YEARS: \_\_\_\_\_

LIST ALL MEDICATIONS/SUPPLEMENTS YOU TAKE REGULARLY (INCLUDE OVER-THE-COUNTER): \_\_\_\_\_

LIST ALL KNOWN ALLERGIES: \_\_\_\_\_

WHAT, IF ANY, ARE YOUR MAJOR PHYSICAL COMPLAINTS? \_\_\_\_\_

MARK ALL INTESTINAL PROCEDURES YOU HAVE EXPERIENCED AND THE YEAR IT TOOK PLACE:

- BARIUM ENEMA \_\_\_\_\_  COLONOSCOPY \_\_\_\_\_  SIGMOIDOSCOPY \_\_\_\_\_  
 COLONECTOMY \_\_\_\_\_  NONE \_\_\_\_\_  OTHER \_\_\_\_\_

HOW MANY BOWEL MOVEMENTS DO YOU HAVE PER DAY? \_\_\_\_\_ PER WEEK? \_\_\_\_\_ DO YOU STRAIN? \_\_\_\_\_

DO YOU USE A STOOL SOFTENER? \_\_\_\_\_ LAXATIVE? \_\_\_\_\_ HERBAL LAXATIVE? \_\_\_\_\_ SUPPOSITORY? \_\_\_\_\_



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**MARK ALL INTESTINAL COMPLAINTS: C = CURRENT CONDITION P = PAST CONDITION O = ONGOING CONDITION**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> ANAL/RECTAL BLEEDING    | <input type="checkbox"/> FATIGUE AFTER EATING | <input type="checkbox"/> MUCOUS IN STOOL      |
| <input type="checkbox"/> ANAL/RECTAL ITCHING     | <input type="checkbox"/> FISSURE              | <input type="checkbox"/> PARASITES            |
| <input type="checkbox"/> ATONIC COLON            | <input type="checkbox"/> FISTULA              | <input type="checkbox"/> RECTAL BLEEDING      |
| <input type="checkbox"/> CARCINOMA               | <input type="checkbox"/> GAS                  | <input type="checkbox"/> RECTAL PAIN          |
| <input type="checkbox"/> CELIAC DISEASE          | <input type="checkbox"/> HARD STOOL           | <input type="checkbox"/> REDUNDANCY PROLAPSUS |
| <input type="checkbox"/> COLITIS                 | <input type="checkbox"/> HEMORRHOIDS          | <input type="checkbox"/> REFLUX/HEARTBURN     |
| <input type="checkbox"/> CONSTIPATION            | <input type="checkbox"/> HERNIA               | <input type="checkbox"/> SPASTIC COLON        |
| <input type="checkbox"/> CRAMPING                | <input type="checkbox"/> HUNGRY ALL THE TIME  | <input type="checkbox"/> STRAINING            |
| <input type="checkbox"/> CROHN'S DISEASE         | <input type="checkbox"/> IBS                  | <input type="checkbox"/> ULCER                |
| <input type="checkbox"/> DIARRHEA                | <input type="checkbox"/> INDIGESTION          | <input type="checkbox"/> NONE                 |
| <input type="checkbox"/> DIARRHEA & CONSTIPATION | <input type="checkbox"/> LACTOSE INTOLERANCE  | <input type="checkbox"/> OTHER _____          |

**MARK ALL APPLICABLE CONDITIONS: C = CURRENT CONDITION P = PAST CONDITION O = ONGOING CONDITION**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> ABDOMINAL GAS        | <input type="checkbox"/> CANDIDA ALBICANS       | <input type="checkbox"/> HEARTBURN       | <input type="checkbox"/> LUNG CONDITION          |
| <input type="checkbox"/> ALLERGIES            | <input type="checkbox"/> CHEMICAL SENSITIVITIES | <input type="checkbox"/> HEPATITIS       | <input type="checkbox"/> LYME DISEASE            |
| <input type="checkbox"/> ANEMIA               | <input type="checkbox"/> CHOLESTEROL HIGH/LOW   | <input type="checkbox"/> HERNIA          | <input type="checkbox"/> LUPUS                   |
| <input type="checkbox"/> ANOREXIA             | <input type="checkbox"/> CHRONIC FATIGUE        | <input type="checkbox"/> HERPES          | <input type="checkbox"/> METAL POISONING         |
| <input type="checkbox"/> ANXIETY              | <input type="checkbox"/> CIRRHOSIS              | <input type="checkbox"/> HEMORRHOIDS     | <input type="checkbox"/> MENOPAUSE               |
| <input type="checkbox"/> APPENDICITIS         | <input type="checkbox"/> DEPRESSION             | <input type="checkbox"/> HYPERTHYROID    | <input type="checkbox"/> NAUSEA                  |
| <input type="checkbox"/> ARTHRITIS            | <input type="checkbox"/> DIABETES               | <input type="checkbox"/> HYPOTHYROID     | <input type="checkbox"/> NERVE DISORDER          |
| <input type="checkbox"/> ASTHMA               | <input type="checkbox"/> ENVIRONMENT SENSITIVE  | <input type="checkbox"/> HYPOGLYCEMIA    | <input type="checkbox"/> PARASITES/FUNGI         |
| <input type="checkbox"/> AUTO IMMUNE          | <input type="checkbox"/> EPSTEIN-BARR           | <input type="checkbox"/> INFERTILITY     | <input type="checkbox"/> PMS                     |
| <input type="checkbox"/> BAD BREATH           | <input type="checkbox"/> FAINTING/DIZZINESS     | <input type="checkbox"/> INSOMNIA        | <input type="checkbox"/> POLYMYALGIA             |
| <input type="checkbox"/> BELCHING             | <input type="checkbox"/> FIBROMYALGIA           | <input type="checkbox"/> IRRITABILITY    | <input type="checkbox"/> PROSTATE                |
| <input type="checkbox"/> BLOATING             | <input type="checkbox"/> FISTULA                | <input type="checkbox"/> KIDNEY STONES   | <input type="checkbox"/> SINUS                   |
| <input type="checkbox"/> BLOOD PRESSURE H/L   | <input type="checkbox"/> FISSURE                | <input type="checkbox"/> LEAKY GUT       | <input type="checkbox"/> SKIN CONDITION          |
| <input type="checkbox"/> BULIMIA              | <input type="checkbox"/> GALLSTONES             | <input type="checkbox"/> LIVER IMBALANCE | <input type="checkbox"/> ULCERS                  |
| <input type="checkbox"/> BURNING/ITCHING ANUS | <input type="checkbox"/> HEADACHES/MIGRAINES    | <input type="checkbox"/> LOW BACK PAIN   | <input type="checkbox"/> URINARY TRACT INFECTION |
| <input type="checkbox"/> CANCER               | <input type="checkbox"/> HEART CONDITION        | <input type="checkbox"/> LOW LIBIDO      | <input type="checkbox"/> VARICOSE VEINS          |



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**INDICATE YOUR DIETARY INTAKE: H = HEAVY (5 – 7X/WK) M = MODERATE (2 – 4X/WK) L – LIGHT (1X/WK) N = NEVER**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> ALCOHOL            | <input type="checkbox"/> DAIRY                | <input type="checkbox"/> ICE CREAM       | <input type="checkbox"/> SEA SALT             |
| <input type="checkbox"/> ALGAE              | <input type="checkbox"/> DECAFFEINATED COFFEE | <input type="checkbox"/> JUNK FOODS      | <input type="checkbox"/> SMOOTHIES            |
| <input type="checkbox"/> ANTACIDS           | <input type="checkbox"/> DECAFFEINATED TEA    | <input type="checkbox"/> NUTS/SEEDS      | <input type="checkbox"/> SODA                 |
| <input type="checkbox"/> ASPRINS            | <input type="checkbox"/> EGGS                 | <input type="checkbox"/> ORGANIC FOODS   | <input type="checkbox"/> SOY                  |
| <input type="checkbox"/> BEANS              | <input type="checkbox"/> FATTY FOODS          | <input type="checkbox"/> PASTA           | <input type="checkbox"/> SUGAR                |
| <input type="checkbox"/> BREAD              | <input type="checkbox"/> FISH                 | <input type="checkbox"/> POULTRY         | <input type="checkbox"/> TOBACCO/CIGARETTES   |
| <input type="checkbox"/> CAFFEINATED COFFEE | <input type="checkbox"/> FLAX FIBER           | <input type="checkbox"/> PROCESSED FOODS | <input type="checkbox"/> VEGETABLES           |
| <input type="checkbox"/> CAFFEINATED TEA    | <input type="checkbox"/> FRIED FOODS          | <input type="checkbox"/> PROTEIN SHAKES  | <input type="checkbox"/> WATER                |
| <input type="checkbox"/> CANDY              | <input type="checkbox"/> FRUIT                | <input type="checkbox"/> PSYLLIUM FIBER  | <input type="checkbox"/> WHEAT/FLOUR PRODUCTS |
| <input type="checkbox"/> CARBONATED WATER   | <input type="checkbox"/> GUM                  | <input type="checkbox"/> RED MEAT        | <input type="checkbox"/> WHOLE GRAINS         |
| <input type="checkbox"/> CHOCOLATE          | <input type="checkbox"/> ICE CREAM            | <input type="checkbox"/> SALT            | <input type="checkbox"/> YOGURT               |

**BRIEFLY DESCRIBE YOUR DIETARY INTAKE:**

BREAKFAST: \_\_\_\_\_

LUNCH: \_\_\_\_\_

DINNER: \_\_\_\_\_

SNACKS: \_\_\_\_\_

DO YOU HAVE FOOD CRAVINGS?  YES  NO IF YES, WHAT DO YOU CRAVE? \_\_\_\_\_

**CONTRAINDICATIONS, RATES, POLICY AND DISCLAIMER FOR COLON HYDROTHERAPY**

**IT IS AN HONOR TO BRING YOU PROFESSIONAL AND COMPASSIONATE SERVICE WHILE YOU ARE IN MY CARE. TO ENSURE YOUR SAFETY AND MAINTAIN THE HIGHEST STANDARDS OF PRACTICE, LISTED BELOW ARE THE CONTRAINDICATIONS, BUSINESS RATES, AND POLICY FOR YOUR REVIEW PRIOR TO RECEIVING SERVICES. PLEASE EMAIL [LIFETIMEHEALTH@COLONLOVE.COM](mailto:LIFETIMEHEALTH@COLONLOVE.COM) OR CALL 617-710-1337 WITH ANY QUESTIONS. THANK YOU.**

**CONTRAINDICATIONS FOR COLON HYDROTHERAPY**

IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS, A PRESCRIPTION FROM YOUR MEDICAL PROVIDER IS REQUIRED FOR SERVICE. WHILE YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR HEALTHCARE CHOICES, YOU ARE ENCOURAGED TO SHARE THIS LIST WITH YOUR PRIMARY HEALTHCARE PROVIDER FOR REVIEW AND APPROVAL.

- |   |                           |                           |
|---|---------------------------|---------------------------|
| SEVERE HEMORRHOIDS                        | FISSURES/FISTULAS         | SEVERE ANEMIA             |
| ANEURYSM                                  | CARCINOMA OF THE COLON    | SEVERE ULCERATIVE COLITIS |
| CROHN'S DISEASE                           | ABDOMINAL HERNIA          | PREGNANCY                 |
| SEVERE DIVERTICULITIS                     | RENAL INSUFFICIENCY       | CIRRHOISIS OF THE LIVER   |
| GI HEMORRHAGE/PERFORATION                 | UNCONTROLLED HYPERTENSION | CONGESTIVE HEART FAILURE  |
| RECENT COLON SURGERY (LESS THAN 3 MONTHS) |                           |                           |



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## SESSION RATES

ONE HOUR SESSION .....	\$ 200
NEW CLIENT (MUST HAVE 1.5 HOUR SESSION TO INCLUDE .5 HOUR CONSULTATION).....	\$ 275
SERIES OF 5 SESSIONS (1 <sup>ST</sup> TIME CUSTOMER 1.5 PLUS 4 COLONICS).....	\$ 995
SERIES OF 5 SESSIONS (REPEAT CUSTOMER) .....	\$ 900
SERIES OF 10 SESSIONS (1 <sup>ST</sup> TIME CUSTOMER 1.5 PLUS 9 COLONICS) .....	\$ 1,855
SERIES OF 10 SESSIONS (REPEAT CUSTOMER) .....	\$ 1,755
SENIOR CITIZEN (65+)/STUDENT (PROOF OF FULL-TIME STATUS) .....	\$ 180
PARAPLEGIC AND QUADRAPLEGIC .....	\$ 250
HALF HOUR COLONIC CONSULTATION (PHONE) .....	\$ 75
COLONOSCOPY PREPARATION (2 SESSIONS) .....	\$ 370

## SESSION EXTRAS

HERBAL TEA BATH PREPARATION .....	\$ 30
DRY SKIN BRUSHING (DURING COLONIC) .....	\$ 40
CASTOR OIL PACK (DURING COLONIC) .....	\$ 50

## YOU ALSO UNDERSTAND AND AGREE TO THE FOLLOWING:

- ◆ ALL SERIES MUST BE USED WITHIN 3 MONTHS. SERIES ARE NON-TRANSFERABLE AND REFUNDS ARE NOT AVAILABLE
- ◆ A 48 HOUR NOTICE IS REQUESTED FOR CANCELLATIONS. REFUNDS ARE SUBJECT TO A \$35 HANDLING FEE
- ◆ A LESS THAN 48 HOUR CANCELLATION NOTICE IS SUBJECT TO A 50% REFUND AND A \$35 HANDLING FEE
- ◆ ALL COLONOSCOPY PREPARATION SESSIONS REQUIRE A 1 WEEK ADVANCED NOTICE
- ◆ TRAVEL TIME IS BILLED AT THE FOLLOWING RATE:
  - 1<sup>ST</sup> 29 MINUTES OF TRAVEL IS **FREE**
  - 30 MINUTES OR MORE OUTSIDE OF BOSTON IS BILLED AT \$1/TRAVEL MINUTE **EACH WAY** (**LESS** 1<sup>ST</sup> 29 MIN)
  - 60 MINUTES OR MORE OUTSIDE BOSTON WILL RECEIVE A 50% TRAVEL DISCOUNT WHEN TWO (2) OR MORE PEOPLES SCHEDULE A COLONIC ON SAME DAY, AT SAME LOCATION OR WITHIN SAME ZIP CODE AREA ONE WEEK OR MORE PRIOR TO APPOINTMENT (TRAVEL REFUND ISSUED TO ORIGINAL PAYMENT METHOD)

**DISCLAIMER** – COLON HYDROTHERAPY IS NOT INTENDED TO REPLACE THE RELATIONSHIP WITH YOUR PRIMARY HEALTH CARE PROVIDERS. THE CONSULTATION IS NOT INTENDED AS MEDICAL ADVICE BUT AS A SHARING OF KNOWLEDGE AND INFORMATION FROM MY EDUCATION, RESEARCH, EXPERIENCE AND HOLISTIC COMMUNITY. AS A COLON HYDROTHERAPIST, I ENCOURAGE YOU TO BE OPEN TO NEW INFORMATION ON THE EFFECTIVENESS OF COLON HYDROTHERAPY AND THE FOUNDATIONAL ROLE OF DIET, EXERCISE, SUPPLEMENTATION, STRESS MANAGEMENT AND EMOTIONAL WORK. I ENCOURAGE YOU TO MAKE YOUR OWN HEALTH CARE DECISIONS BASED UPON YOUR RESEARCH AND IN PARTNERSHIP WITH YOUR PRIMARY HEALTH CARE PROVIDERS. THE INFORMATION AND SERVICE PROVIDED IS NOT USED TO PRESCRIBE, RECOMMEND, DIAGNOSE OR TREAT A HEALTH PROBLEM OR A DISEASE. IT IS NOT A SUBSTITUTE FOR MEDICAL CARE. IF YOU HAVE OR SUSPECT YOU MAY HAVE A MEDICAL CONDITION, YOU SHOULD CONSULT YOUR PRIMARY HEALTH CARE PROVIDERS.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



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**COLON HYDROTHERAPY SETUP:**

PLEASE NOTE THAT PLUMBING IS ***NOT*** REQUIRED FOR COLON HYDROTHERAPY WATER CONNECTIONS. TO ENSURE A PROPER CONNECTION BETWEEN THE BATHROOM/KITCHEN WATER SOURCE, WATER INFLOW LINES, AND THE COLON HYDROTHERAPY INSTRUMENT, PLEASE ANSWER THE NEXT FEW QUESTIONS ACCURATELY.

HOW MANY BATHROOMS DO YOU HAVE IN YOUR HOUSEHOLD, OFFICE, HOTEL, ETC.? ONE TWO THREE FOUR OTHER

DESCRIBE YOUR BATHROOM SINK. \_\_\_\_\_

EXAMPLE: Separate hot and cold faucet or one faucet controlling the hot/cold water.

DESCRIBE YOUR KITCHEN SINK. \_\_\_\_\_

EXAMPLE: One gooseneck faucet supplying the hot/cold water.

PROVIDE ANY ADDITIONAL COMMENTS. \_\_\_\_\_

\_\_\_\_\_