VITALITY SOURCE INTERNAL CLEANSE AND DETOX STUDIO
- Intake Form -

Today's Date: _____

First Name: JENNIFER **Last Name:** JENNIFER

Address: _____ **Apt #:** _____

City: _____ **Postal Code:** _____

Email: _____

Telephone (Home): _____ **(Cell):** _____

Date of Birth (mm/dd/yy): _____ **Occupation:** _____

Are you on medication? ○YES ◉NO If yes, please list: PRISTIG / COLOZOPAN / ANTIBIOTIC

Do you take Natural Supplements? ◉YES ○NO If yes, please list: OCCASIONAL - MILK THISTLE - SILICA

Do you need diet/nutritional advice? ◉YES ○NO Are you interested in weight loss? ◉YES ○NO

What kind of exercise do you do? NONE Blood Type: ___

What brings you in for colon therapy? UNWELL IN ALL WAYS - A LOT MENTALLY

What is your current level of stress? ○Minimal ○Average ◉High

How many hours do you sleep in the night? VARIES Additional Comments: _____

Are you Pregnant? ○YES ◉NO If yes, how far along are you? _____

Do you Smoke? ○YES ◉NO If yes, for how long? _____ How many cigarettes per day? _____

Have you had any operations? ◉YES ○NO If yes, please specify: KNEE

Are you currently on a cleanse? ○YES ◉NO If yes, what kind? _____

Check off the items you consume the most of:

○ Red Meat ○ Poultry ○ Fish ○ Vegetables ☑ Fruit ☑ Dairy ☑ Wheat

☑ Fast Food ☑ Sweets ☑ Coffee ○ Tea ☑ Alcohol ○ Pop

How many glasses of water do you drink per day? 0 - 1 **Weight:** 140

Please check any of the following that apply to you:

○ IBS ○ Colitis ○ Crohn's ○ Ulcers ○ Diverticulitis ○ Diabetes ○ Polyps

○ Gallstones ○ Kidney Stones ○ Anal Fissure ○ Haemorrhoids ○ Intestinal Perforation

Do you experience the following difficulties?

☑ Constipation ☑ Bloating ☑ Gas ☑ Heartburn ○ Burping ○ Diarrhea ○ Abdominal Pain

○ Fatigue ○ Headache ☑ Joint Pain ○ Rectal Bleeding ○ Allergies (If yes, please specify:) _____

Stool Indicators (check which applies):

Bowel Movements: Per day: 0 Per week: 1 - 2

What is the consistency?

○ Thin ☑ Watery ○ Well-formed ○ Hard ☑ Mucous ☑ Strong smell ○ Oily ○ Floating

Describe colour: BROWN - FOR ALONG TIME IT WAS LIGHT BROWN OR YELLOW, WITH FOOD BITS IN IT

Is there anything else you wish to discuss? RASHES, ACNE, HIVES LIKE BUMPS ON ARMS - BRAIN FOG, SWEATY, TIRED

How did you hear about us? DIZZY, POOR MEMORY, SCATTERED recurring yeast infections

If someone referred you, please tell us who so we can thank them: _____

Signature: _____ Date signed: _____