Client Name: _____ Date of Birth:_____Appointment Date:_____

REQUIRED RESPONSES:

Are you under the age of 18 years old?

- ☐ No
- ☐ Yes **(If yes, please complete a minor's consent form)**

Following your session you may be contacted by a Care Team member to check in.

How would you prefer the Care Team to contact you?
(choose one)

- ☐ Phone
- ☐ Email

What time of day is best for a Care Team member to contact you?:
(choose one)

- ☐ Morning
- ☐ Afternoon
- ☐ Evening

SECTION ONE: A few legalities, precautions, and clarifications

Please check all allergies and provide information if necessary.

- ☐ Latex Allergy
- ☐ Sulfur Allergy

If you have any life threatening allergies please list them below and provide emergency contact information.

If you have any contagious diseases, please explain below:

Are you currently working on specific health issue(s) with a doctor? If yes, please explain.

Are you actively treating a cancer diagnosis? If so, please elaborate, including supervising physician.

Do you have a prescription from a caregiver to receive services here? If yes, please explain.

List the medications you take currently.

List the supplements you take currently.

List the bodywork care you've received recently (i.e. massage, acupuncture, etc.).

Please list a brief description of your current 3-5 health/wellness goals

SECTION TWO: Your Nervous System (Your Capacity to Heal)

Rate the current stress level in your life from 1-10: 1 = vacation and 10 = life in danger:
1 2 3 4 5 6 7 8 9 10

Select any/all stressors you've experienced and the timeframe for each:

Death or Serious Illness of Family or a Close Friend:
- ☐ 0-6 months
- ☐ 6-12 months
- ☐ 1-4 years
- ☐ 5-10 years
- ☐ 10+ years

Divorce, Separation, or Relationship Challenges:
- ☐ 0-6 months
- ☐ 6-12 months
- ☐ 1-4 years
- ☐ 5-10 years
- ☐ 10+ years

Job Loss, Significant Change or Challenge:
- ☐ 0-6 months
- ☐ 6-12 months
- ☐ 1-4 years
- ☐ 5-10 years
- ☐ 10+ years

Move Your Residence:
- ☐ 0-6 months
- ☐ 6-12 months
- ☐ 1-4 years
- ☐ 5-10 years
- ☐ 10+ years

Major Illness or Accident:
- ☐ 0-6 months
- ☐ 6-12 months
- ☐ 1-4 years
- ☐ 5-10 years
- ☐ 10+ years

Please explain any other highly stressful events, (with timeframe) below:

Have you experienced any of these feelings recently? (Check all that apply.)

- ☐ Overwhelmed
- ☐ Weepy
- ☐ Irritable
- ☐ Hopeful

Do you experience nervousness and/or anxiety?
- ☐ Never/Rarely
- ☐ Occasionally
- ☐ Regularly
- ☐ Daily

Does your level of mental activity become stressful, distracting or otherwise uncomfortable?
- ☐ Never/Rarely
- ☐ Occasionally
- ☐ Regularly
- ☐ Daily

What best describes your sleep habits? (Check all that apply.)

- ☐ I fall asleep easily
- ☐ I have trouble falling asleep
- ☐ I wake up in the night and **easily** fall back to sleep
- ☐ I wake up in the night and **can't** fall back to sleep

Check the times you experience energy dips during the day when you don't use stimulants (coffee, black tea, sugar). (Check all that apply.)

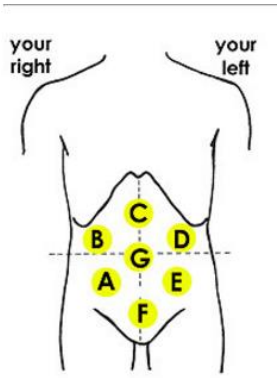
- ☐ Upon waking
- ☐ Mid-morning
- ☐ After lunch
- ☐ Mid-afternoon
- ☐ Late afternoon
- ☐ After dinner
- ☐ Evening
- ☐ I don't know because I always use stimulants
- ☐ None of the above

SECTION THREE: Your Digestive System (Your Capacity to Nourish & Eliminate Waste)

Check all of the following symptoms and diagnosed conditions related to your digestion.

- ☐ Candidiasis (yeast overgrowth)
- ☐ Colitis
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Flatulence (passing gas)
- ☐ Food Allergies
- ☐ Halitosis (bad breath)
- ☐ Heavy mucus production
- ☐ Indigestion (heart burn / acid reflux)
- ☐ Intestinal gas (bloating)
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Parasites
- ☐ Spastic colon

Check all areas in which you experience pain (referring to the body diagram below).



- ☐ Area A
- ☐ Area B
- ☐ Area C
- ☐ Area D
- ☐ Area E
- ☐ Area F
- ☐ Area G

How many bowel movements (on average) do you have?:

- ☐ 1/day
- ☐ 2-3/day
- ☐ 4+/day
- ☐ Every other day
- ☐ Once a week
- ☐ Once a month
- ☐ Only with the support of a laxative, stool softener, or enema

What is the consistency of your stool? (Check all that apply.)

- ☐ Unformed
- ☐ Formed
- ☐ Hard
- ☐ Runny
- ☐ Pencil thin or flat

How would you describe your bowel eliminations? (Check all that apply.)

- ☐ Complete and easy
- ☐ Incomplete
- ☐ Painful
- ☐ Explosive
- ☐ Strained

How long is your transit time? (The time between eating and the elimination of what was eaten):

- ☐ Don't know
- ☐ 12 hours
- ☐ 24 hours
- ☐ 2 days
- ☐ 3 days

What is your history of abdominal surgeries? (Check all that apply.)

- ☐ Appendectomy
- ☐ Bowel resection
- ☐ C-section
- ☐ Cosmetic
- ☐ Exploratory
- ☐ Gall bladder removal

- ☐ Hernia
- ☐ Hysterectomy – abdominal incision
- ☐ Hysterectomy – vaginally removed
- ☐ Organ transplant

Please provide details below:

Please check all applicable contraindications for Colon Hydrotherapy.

If you have experienced any of the following contraindications in the last 3 months, you will need to present a doctor's prescription to receive colon hydrotherapy. Please bring your prescription to your appointment! If you're scheduling for colon hydrotherapy with a contraindication, but do not have prescription, please call us immediately at 206.729.6211.

INTESTINAL ISSUES

- ☐ Recent abdominal, colon, or rectal surgery
- ☐ Cancer or tumors of the colon, rectum, or GI (gastrointestinal track)
- ☐ Untreated abdominal hernia
- ☐ Active ulcerative colitis
- ☐ Active and severe abdominal pain
- ☐ Crohn's disease
- ☐ Diverticulitis (Diverticula in the inflammatory state)
- ☐ Active Fissures or fistula
- ☐ Intestinal perforation
- ☐ Recent history of GI or rectal bleeding
- ☐ Severe (inflamed or bleeding) Hemorrhoids
- ☐ Cirrhosis (widespread nodules in the liver combined with fibrosis)

HEART CONDITIONS

- ☐ Congestive heart failure
- ☐ Recent heart attack
- ☐ Uncontrolled hypertension
- ☐ Vascular aneurism

NEUROLOGICAL CONDITIONS

- ☐ Psychoses
- ☐ History of seizures or epilepsy

OTHER

- ☐ Currently pregnant

SECTION FOUR: Your Lymphatic/Immune Systems + Skin (Your Capacity to Detoxify & Protect)

Do you experience swelling (fluid retention) anywhere in your body? :

- ☐ Yes
- ☐ No
- ☐ I don't know

If yes, please describe:

Do you experience inflammation (pain) in specific areas of your body?:

- Yes
- No
- I don't know

If yes, please describe.

Do you experience inflammation (pain) systemically throughout your body? :

- Yes
- No
- I don't know

If yes, please describe.

Do you have known allergies and reactions?

- Yes
- No
- I don't know

If yes, please describe:

Do you have known autoimmune issues?

- Yes
- No
- I don't know

If yes, please describe:

Do you have known suppressed immune system issues?

- Yes
- No
- I don't know

If yes, please describe:

Do you currently supplement your immune system with the following?

Vitamin C :
- ☐ Never/Rarely
- ☐ Occasionally
- ☐ Regularly
- ☐ Daily

Probiotics (friendly bacteria):
- ☐ Never/Rarely
- ☐ Occasionally
- ☐ Regularly
- ☐ Daily

Vitamin D :
- ☐ Never/Rarely
- ☐ Occasionally
- ☐ Regularly
- ☐ Daily

Essential Fatty Acids—Omega 3, 6, 9 Oils:
- ☐ Never/Rarely
- ☐ Occasionally
- ☐ Regularly
- ☐ Daily

Please check all skin conditions that you have experienced or are currently experiencing

- ☐ Acne
- ☐ Eczema
- ☐ Hives
- ☐ Premature aging
- ☐ Psoriasis
- ☐ Scars
- ☐ Sun damage

Please describe:

Please check if you have any of the following contraindications for Electro-Lymphatic Therapy.

- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Deep vein thrombosis

SECTION FIVE: Your Muscular Skeletal System (Your Capacity for Movement and Stability)

Do you experience pain in any of the following areas? (Check all that apply.)
- ☐ Head
- ☐ Neck/Shoulders
- ☐ Back (upper)
- ☐ Back (middle)
- ☐ Back (lower)
- ☐ Hips
- ☐ Knees
- ☐ Feet
- ☐ Other (please describe)

Have you had any of the following? (Check all that apply.)

- ☐ Broken bones
- ☐ Bursitis
- ☐ Scar tissue
- ☐ Sprains
- ☐ Tendonitis
- ☐ Vehicle accidents

- ☐ Significant falls

Please provide details, dates, and any recovery/healing complications.

Generally speaking, check all that apply to how your body feels.

- ☐ Active
- ☐ Flexible
- ☐ Sluggish
- ☐ Sore
- ☐ Stiff

SECTION SIX: Women's Reproductive Health

Do you currently use birth control?

- ☐ Yes
- ☐ No

If yes, list all methods used.

Do you experience menses with your birth control?

- ☐ Yes
- ☐ No

Please check all of the following you have experienced in your life.

- ☐ Ovarian Cysts
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Painful menses (periods)
- ☐ Amenorrhea (no periods)
- ☐ Fertility challenges

Provide details below:

Dates of pregnancies:

Dates of vaginal births:	Dates of C-sections:

Dates of miscarriages, abortions, still births:

Date of your last menstrual period:

Menopause: If relevant, please provide estimated date of onset and whether it was natural or surgical.

SECTION SEVEN: Your Diet & Lifestyle (Your Framework to Support Health)

Check all that have been part of your lifestyle within last 6 months:

- ☐ Alcohol
- ☐ Antibiotics
- ☐ Caffeine
- ☐ Chemical Laxatives
- ☐ Dairy (Organic)
- ☐ Dairy (Non-Organic)
- ☐ International Travel
- ☐ Fruits and Vegetables (Organic)
- ☐ Fruits and Vegetables (Non-Organic)
- ☐ Meats (Organic)
- ☐ Meats (Non-Organic)
- ☐ Recreational Drugs
- ☐ Cannabis
- ☐ Tobacco

Do you exercise regularly? If yes, describe type and frequency below.

Do you have a regular spiritual, contemplative, or meditative practice?

Do you have a supportive connection to close friends, family, community?

Please describe the most common foods you eat OR give an example of your daily diet.

Notices of Clarity: With the exception of those identified as an "ND" (Naturopathic Doctor), Tummy Temple team members are not doctors. They do not offer medical diagnoses, cures, advice, or treatment for any medical disease, ailment, injury, infirmity, deformity, pain, or other physical or mental condition. They do not prescribe or recommend alterations of any prescription drugs or their protocols. Any information on products and services offered by non-ND staff is wellness care.

Massage (LMP) and Nutrition (CN) licenses do not include colonics in their scope of training, certification, or practice.

By signing below I indicate that I've read these notices AND the Terms and Conditions (see clipboard for attached document)

Name (PRINTED): _____

Name (SIGNED): _____ Date: _____