



Glastonbury Naturopathic Center
 18 School Street, Glastonbury, CT 06033
 Dr. Helene Pulnik, N.D., Medical Director
phone 860.657.4105
www.cleanmycolon.com
www.naturopathicwellness.com

Health Questionnaire

Please help us provide you with the most appropriate and effective service by completing the following questions. All information is kept confidential.

PERSONAL DATA (please print)

First Name _____ Last Name _____

Address _____ City/State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

E-mail (for appt. confirmations, news, and special offerings) _____

Occupation _____ Date of Birth _____ Gender _____

Primary physician _____ Physician's Phone _____

HOW DID YOU FIND US?

- Practitioner (name & specialty) _____ Connecticut Holistic Health Association
- Physician (name & specialty) _____ Natural Nutmeg
- Friend (friend's name) _____ Natural Awakenings
- Directories/Yellow Pages _____ naturopathicwellness.com
- Internet search (specify) _____ cleanmycolon.com

COLON HEALTH

Is this your first Colon Hydrotherapy session? Yes No

If not, where and when was your most recent visit? _____

What, if any, is your prior experience with colon cleansing, other than hydrotherapy?

fasting juicing herbs enemas other _____

If you use laxatives and/or stool softeners, how often? _____

Are you currently fasting? Yes No Are you currently cleansing? Yes No

If yes, describe cleanse program: _____

My intention for hydrotherapy is: _____

Which of the following apply to you? C = Currently P = Past S = Sometimes

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Carcinoma | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Abdominal spasms | <input type="checkbox"/> Celiac disease | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Acid reflux/heartburn | <input type="checkbox"/> Colitis | <input type="checkbox"/> Gas after eating | <input type="checkbox"/> Pelvic pain |
| <input type="checkbox"/> Anal discomfort/itching | <input type="checkbox"/> Constipation | <input type="checkbox"/> Gastroparesis | <input type="checkbox"/> Polyps |
| <input type="checkbox"/> Anal /rectal bleeding | <input type="checkbox"/> Cramping | <input type="checkbox"/> Hernia | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Crohn's | <input type="checkbox"/> Hungry all the time | <input type="checkbox"/> Reduntant/prolapsed colon |
| <input type="checkbox"/> Atonic colon | <input type="checkbox"/> Diverticulitis/osis | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Spastic colon |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Fatigue after eating | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Belching / Bloating | <input type="checkbox"/> Fissure / Fistula | <input type="checkbox"/> Lactose intolerance | <input type="checkbox"/> Worms in stool |

Please list any intestinal-related procedures you have had, along with the year it took place:

- barium enema, year _____ colonoscopy, year _____ sigmoidoscopy, year _____
 abdominal surgery, year _____ bariatric surgery, year _____ gasteric bypass, year _____
 pelvic surgery, year _____

BOWEL HEALTH

How many bowel movements do you usually have? Per day _____ Per week _____

Do you strain to have a movement? Yes No Does the movement feel complete? Yes No

Please check applicable responses. The stool . . .

- Shows signs of mucus Shows signs of blood Has a strong odor

Do you experience diahrrea? No Yes Frequency: _____

Do you currently have hemorrhoids? No Yes Severity: _____ Bleeding: _____

GENERAL HEALTH

What is your blood type? A AB B O

Have you been hospitalized within the past year? _____ in the last 5 years? _____

Why? _____

Which of the following apply to you? C = Currently P = Past

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Allergies (see below) | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Mental disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Nerve disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dizziness | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Irregular menstrual cycle | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Edema | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Prostate condition |
| <input type="checkbox"/> Auto immune disorder | <input type="checkbox"/> Environmental sensitivities | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Renal insufficiency |
| <input type="checkbox"/> Bloodclot/vessel disorder | <input type="checkbox"/> Epstein-Barr | <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Sinus condition |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Extreme weight gain/loss | <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Skin condition |
| <input type="checkbox"/> Candida | <input type="checkbox"/> Fainting | <input type="checkbox"/> Low libido | <input type="checkbox"/> Sweats |
| <input type="checkbox"/> Chemical toxicity | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Lung disorder | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Cholesterol high/low | <input type="checkbox"/> Fever/chills | <input type="checkbox"/> Lupus | <input type="checkbox"/> Toxicity |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Fibro/polymialgia | <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Fibroid cysts | <input type="checkbox"/> Metal poisoning | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Currently _mnths pregnant | <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Menopause | <input type="checkbox"/> Urinary tract infection |

Please describe any allergies you may have: _____

Have you been recently diagnosed with a major illness? Please describe: _____

Have you recently had chemotherapy or radiation? _____ When? _____

Do you use any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> antibiotics _____ | <input type="checkbox"/> prescription drugs (please list) _____ | <input type="checkbox"/> supplements (please list) _____ |
| <input type="checkbox"/> over-the-counter drugs _____ | _____ | _____ |
| <input type="checkbox"/> pacemaker (how long?) _____ | _____ | _____ |
| <input type="checkbox"/> prescribed birth control _____ | _____ | _____ |
| <input type="checkbox"/> probiotics _____ | <input type="checkbox"/> antidepressants (please list) _____ | _____ |
| <input type="checkbox"/> recreational drugs _____ | _____ | _____ |
| <input type="checkbox"/> steroids _____ | _____ | _____ |

DIET

Using the following key, please indicate your dietary usage:

F = Frequent (5-7 times a week) M = Moderate (2-4 times a week) L = Light (once a week or less)

R = Rarely (1 times/2 times per month or less) N = Never (really, never!)

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Chocolate | <input type="checkbox"/> Fried Foods | <input type="checkbox"/> Poultry | <input type="checkbox"/> Soda |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Dairy | <input type="checkbox"/> Fruit | <input type="checkbox"/> Popcorn | <input type="checkbox"/> Soy |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Decaf Coffee / Tea | <input type="checkbox"/> Gum | <input type="checkbox"/> Processed Foods | <input type="checkbox"/> Sugar |
| <input type="checkbox"/> Beans | <input type="checkbox"/> Desserts | <input type="checkbox"/> Ice Cream | <input type="checkbox"/> Protein Shakes | <input type="checkbox"/> Tobacco/cigarettes |
| <input type="checkbox"/> Bread | <input type="checkbox"/> Eggs | <input type="checkbox"/> Junk Food | <input type="checkbox"/> Psyllium Fiber | <input type="checkbox"/> Vegetables |
| <input type="checkbox"/> Coffee/Tea | <input type="checkbox"/> Fatty Foods | <input type="checkbox"/> Milk | <input type="checkbox"/> Red Meat | <input type="checkbox"/> Water |
| <input type="checkbox"/> Candy | <input type="checkbox"/> Fish | <input type="checkbox"/> Nuts / Seeds | <input type="checkbox"/> Salads | <input type="checkbox"/> Wheat/flour products |
| <input type="checkbox"/> Carbonated Water | <input type="checkbox"/> Fish Oil | <input type="checkbox"/> Organic Foods | <input type="checkbox"/> Salt | <input type="checkbox"/> Whole Grains |
| <input type="checkbox"/> Cheese | <input type="checkbox"/> Flax Fiber | <input type="checkbox"/> Pasta | <input type="checkbox"/> Smoothies | <input type="checkbox"/> Yogurt |

Please describe any food sensitivities you may have: _____

BRIEFLY DESCRIBE YOUR TYPICAL DIETARY INTAKE FOR THE FOLLOWING MEALS

Breakfast _____

In Between _____

Lunch _____

In Between _____

Dinner _____

After _____

Snacks / Desserts _____

Do you have any food cravings? No Yes _____

LIFESTYLE:

Are you currently under any excessive or unusual mental or physical stress? Please describe briefly:

How do you relax? _____

Do you exercise? No Yes What forms of exercise do you do? _____

Do you practice any forms of: Meditation Prayer 12 Step-Program Other _____

Are you, or have you been, addicted to: C = Currently P = Past

Alcohol Coffee Sugar Tobacco Drugs Prescription drugs Other _____

If there are other areas of your life/lifestyle (such as emotional, mental, or physical trauma) that you feel would be appropriate for us to know in order to better meet your needs, please comment in the space below. All information is strictly confidential.

Client Signature: _____ Date: _____



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Informed Consent

I, the undersigned, authorize Constance Jones or other certified colon hydrotherapists working with Glastonbury Naturopathic Center to administer Colon Hydrotherapy sessions. None of the certified colon hydrotherapists is a physician and therefore not qualified to diagnose or prescribe. As with any procedure, there are potential benefits and risks associated with it. I understand how Colon Hydrotherapy is performed and used, and I acknowledge the potential benefits and risks of it as described below:

Colon Hydrotherapy (or a *colonic*) is a gentle, purified water-washing of the large intestine. The client lies on a padded table and, with a Colon Hydrotherapy instrument, purified and triple-filtered water is run very slowly into the colon by the practitioner. When slight pressure builds up in the colon, the practitioner reverses the water flow to empty. As the water and waste are flowing out through an illuminated glass viewing tube, pressure points may be stimulated. This process is repeated several times during the period for 45-55 minutes. During one session, a total of approximately 2-5 gallons flows into and out of the large intestines. **Glastonbury Naturopathic Center uses a closed Colon Hydrotherapy system with single-use, disposable speculum and tubing. The Colon Hydrotherapist is *always* present in the room with the client during each session.**

Colon Hydrotherapy may be used to cleanse the colon by removing fecal material, gas, and mucus. It may also be prescribed by a physician in preparation for the diagnostic study of the large intestine or for other conditions.

Potential risks may include possible aggravation of symptoms existing prior to the session, digestive distress, appetite changes, or energy changes.

Possible contraindications are: aneurysm, severe cardiac disease, severe anemias, GI hemorrhage/perforation, severe hemorrhoids, cirrhosis, colo-rectal cancer, fissures/fistulas, advanced pregnancy, abdominal hernia, and recent colon surgery (within six months). *If you have any of these conditions or are taking certain medications, you must consult Dr. Pulnik or your physician before your first Colon Hydrotherapy session. Connie or another certified colon hydrotherapist will review your questionnaire at the first visit before you receive Colon Hydrotherapy to determine whether or not this procedure is appropriate for you.*

- I affirm that I understand the purpose and potential benefits of Colon Hydrotherapy.
- I understand and freely accept the potential risks of the procedure.
- An offer has been made to answer any questions I have about the procedure.
- I freely and voluntarily consent to the above procedure.
- I realize that no guarantee as to the results that may be obtained has been given to me by Constance Jones, other certified colon hydrotherapists, Glastonbury Naturopathic Center, or Helene Pulnik, N.D.
- I hereby release Constance Jones, other certified colon hydrotherapists, Glastonbury Naturopathic Center, or Helene Pulnik, N.D. from any and all liability which may occur in connection with the above mentioned procedure.
- I understand that I am free to withdraw my consent and to discontinue participation in this procedure at any time.
- I am not acting as an agent for any government agency, law office, or pharmaceutical company.

Signature of Patient (or Guardian if under age 18):

Signature _____ Date _____



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Services and Fees

COLON HYDROTHERAPY FEES	
60-minute session	\$122.00
Series of three 60-minute sessions	\$343.00
90-minute session	\$168.00
Series of three 90-minute sessions	\$472.00

SUPPLEMENTATION	
Colon Supplementation Procedure	Add \$20
Probiotic Additive	Add \$30

Payment for service is expected in full at the time it is rendered. We accept cash, checks, and credit cards.

- Ⓢ Our cancellation fee is the full amount of the missed appointment if NOT cancelled one business day (at least 24 hours) prior to the appointment date.
- Ⓢ As a reminder, we will call you prior to your appointment, but your appointment is considered CONFIRMED at the time it is made.
- Ⓢ Special Discount Packages must be paid in full at the first session and are nonrefundable and nontransferable. Sessions must be used within six months from date of purchase.
- Ⓢ It is Glastonbury Naturopathic Center’s policy that you keep your account current.
- Ⓢ Insurance does not cover the cost of Colon Hydrotherapy. You may request a superbill, which includes all necessary codes to submit to your insurance company for possible reimbursement through HSAs, FSAs, etc.

I understand and agree that I am responsible for the balance on this account for services including Colon Hydrotherapy fees, supplements, and any fees charged to me for missed or late cancellations of appointments.

I have read and understand the above services and fees, as well as the payment and cancellation terms, and agree to abide by them.

Signature of Patient (or Guardian if under age 18):

Signature _____ Date _____