THE CLEANSING CENTER
CLIENT INTAKE EVALUATION

Name: ____________________________________ Date__________________

Phone______/______-_________ email: ___________________________________

Street: ____________________________________ City _______________________

State ____ Zip__________

What Service are you here for?____

Why do you want this service?____

____

How you found out about us: fax / friend / internet / Naturally Yours Magazine /

(other)_________________

What do you do for a living?____________________________________

Did you ever work in: construction: yes / no | auto repair: yes / no | painting: yes / no | machine shop: yes / no | chemical plant: yes / no | pottery: yes / no | dry cleaning: yes / no |

Allergies____

DOB____/____/____ Age__________

Male___Female___ Height__________ Weight_________

Medications: Prescription/ Nonprescription/ Herbals/ Vitamins

Medication_______________ Dose Frequency________ Last Dose________

Medication_______________ Dose Frequency________ Last Dose________

Medication_______________ Dose Frequency________ Last Dose________

Medication_______________ Dose Frequency________ Last Dose________

Medication_______________ Dose Frequency________ Last Dose________

Surgeries/Date____

Past Hospitalizations/Date____

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

Hypertension________ Hepatitis________ Renal________ Respiratory________
Diabetes________ Stroke________ Heart Disease________ Seizures________ Mental Health
Issues_________ Renal Disease________ Abnormal Bleeding________ Glaucoma________

ARE YOU EXPERIENCING CONSTIPATION: yes / no

Hard stools: yes / no

Fully evacuating (does it feel like there is more feces stuck in you?): yes / no

Diet with low fiber and high meat/cheese or processed foods: yes / no

Incontinence: yes / no | Pain: yes / no | Blood In Stool: yes / no | Hemorrhoids: yes / no |

Last Bowel Movement_________________________________

Previous Interventions: None / Laxatives / Enemas / Other___________________________
Frequency of Bowel Movements____________Describe Bowel Movements: Color___________

Consistency of Bowel Movements: (circle all that apply): thin, thick, hard, soft, watery, small round, clay like

Are you experiencing?: Nausea: YES / NO; Dizziness: YES / NO; Vomiting: YES / NO; Pain: YES / NO.

CONTRINDICATIONS FOR COLON HYDROTHERAPY. *DO YOU HAVE:*

congestive heart failure YES / NO | *diverticulitis* YES / NO | *ulcerative colitis* YES / NO | *Crohn's disease* YES / NO | *severe or internal hemorrhoids* YES / NO | *tumors in the rectum or colon* YES / NO | *intestinal perforation* YES / NO | *carcinoma of the rectum* YES / NO | *fissures or fistula* YES / NO | *severe hemorrhoids* YES / NO | *abdominal hernia* YES / NO | *renal insufficiency* YES / NO | *recent colon or rectal surgery* YES / NO | *cirrhosis of the liver* YES / NO | *and first and last trimester of pregnancy* YES / NO | **ALL CURRENT CONDITIONS SHOULD GIVE RISE FOR CONCERN & PATIENT SHOULD HAVE PHYSICIAN APPROVAL TO HAVE COLON IRRIGATION TREATMENT. I __________________________ acknowledge I do not have ANY of the above referenced contraindications for Colon Hydrotherapy. Signature** *X* ___________________________________

Alcohol Use: yes / no | How Much: ___________ | How Long: ___________

Tobacco Use: yes / no | Type: cigars___; cigarettes____ pipe___ #per day________

Do You Live w/Someone Who Smokes: yes / no | Current Recreational Drug Use: yes / no | Former Use: yes / no | Describe____

Medical Conditions____

Previous Hospitalizations____

Surgeries____

Why Are You Here?: ____

How Did Your Problem Present Itself? ____

How Is Your General Health? ____

Have You Been Able To Follow Prescribed Medications/Treatments? yes/no If "no" why not?____

Chelation Therapy Is Still Considered Experimental and Patients Must Understand Risks and Alternatives To Such Treatment Prior to Starting. Consult your primary care physician prior to starting Chelation Therapy.

Also beware that there are no definitive tests to determine the exact levels of toxic metals in your system. Blood, hair, fecal, radiographic, or challenge urine toxicity testing is only a general determinant that toxic metals are in your system; as metals settle into different organs depending on age, metal and nutritional status. We utilize challenge urine toxicity testing as a general indicator of toxic metals. Many laboratory tests are formulated to show heavy metal levels without use of a chelating agent (EDTA or DMSA) use of such chelating agent will greatly increase the metal levels shown and will exaggerate the results by pulling the metals from soft tissue and bone; and therefore can not accurately predict levels of heavy metals; but will show a rough estimate of what metals are coming out of your system. There are safe levels of toxic metals according to government standards; but in Preventive Medicine the ideal is to eliminate completely ALL toxic metals. X_____________________________________(Patient Acknowledgement)

Family Physician____

I ______________________________(patient name) acknowledge and understand that Kenneth Lewandowski, D.O. and The Cleansing Center, Inc. is NOT my primary Medical Doctor and ALL medical decisions regarding any current or future health conditions should be addressed by my primary care physician. The Cleansing Center serves as only a resource for general wellbeing and preventive medicine and does NOT treat any existing illness.

X _______________________________ __________

Signature Date

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I,________________________________, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- ı I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement;
- ı This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Patient ……………………………………………..Date: ………………

HIPAA Privacy Rule of Patient Authorization & Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, ____________________________________, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

• a basis for planning my care and treatment;
• a means of communication among the health professionals who may contribute to my healthcare;
• a source of information for applying my diagnosis and surgical information to my bill;
• a means by which a third-party payer can verify that services billed were actually provided;
• a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.
Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:
• I have the right to review this facility's Notice of Information practices prior to signing this consent;
• This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
• I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
• I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
• It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient ……………………………………………….. Date: ………………