

Client Health Questionnaire

CONTACT INFORMATION

Name: _____ Date: _____

Address: _____

Phone: _____ (hm) _____ (wk) _____ (mbl)

Email Address: _____

Date of Birth: _____ Height: _____ Weight: _____

Sex: Male Female Marital Status: Married Single Other

Children: _____ Ages: _____

Occupation: _____

Hobbies & Activities: _____

Emergency Contact Information: _____

Relationship: _____ Phone 1: _____ Phone 2: _____

Physician: _____ Phone: _____

Are you currently under a doctor's care? Yes No (If YES, explain below)

Date of last complete Physical Exam: _____ Results: _____

Is your Physician aware of you receiving colon hydro-therapy? Yes No

Have you ever had colon hydro-therapy? Yes No (If YES, explain where and when below)

How did you learn of our services? _____

Please state your reasons for and expectations from receiving colon hydro-therapy:

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FOR WOMEN ONLY

Yes No

Are you pregnant?

Are your periods regular?

Do you take birth control pills?

Yes No

Is there a chance you might be pregnant?

Do you suffer from PMS?

Do you take Hormone supplements?

FOR MEN ONLY

Yes No

Do you have difficulties urinating?

Are you experiencing ED difficulties?

Yes No

Do you take Hormone supplements?

Date of last Colonoscopy: _____

Please explain all yes answers below:

DAILY HABITS

What is a typical:

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Daily Water Consumption: _____

Beverages: _____

Alcohol: _____

What and How often: _____

Rec. Drugs _____

Yes No

Do you exercise?

Describe: _____

Please describe your dietary intake: (example; vegan, vegetarian, food combining, non-vegetarian-beef, pork, poultry, seafood, home cooking, home/dinning out, fast food, etc.)

On a scale from 1 5, (with one being low and five being very high) what best describes your usual daily stress level? (circle one) 1 2 3 4 5

Are circumstances in your life increasing your usual stress level? (you may share if you wish)

Yes No

Are you interested in learning more about diet and lifestyle changes?

Client Health Questionnaire

VITAL HEALTH INFORMATION

In order to provide the best possible care and to insure optimum results from you colon hydro-therapy session, the following information is essential. Please complete this section thoroughly and completely. All information contained herein, is strictly confidential.

(Please list all and for what purpose)

Prescription Medications: _____

Supplements: _____

Over the Counter Medications: _____

List all known allergies: _____

List the type and year of all surgeries and major illnesses: _____

Have you ever had? (If yes, when)

- Colonoscopy Sigmoidoscopy Barium Enema Rectal Surgery

Have you ever been treated for any of the following conditions? (Check all that apply)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Cancer | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Abdominal Surgery |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ileitis | <input type="checkbox"/> IBS | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Leaky Gut Syndrome | <input type="checkbox"/> Severe Anemia | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Renal Insufficiency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Colitis | <input type="checkbox"/> Fissures/Fistulas |
| <input type="checkbox"/> Cardiac Disease | <input type="checkbox"/> GI Hemorrhage | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Abdominal Hernia |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> /Perforation | <input type="checkbox"/> HIV | <input type="checkbox"/> AIDS |
| | <input type="checkbox"/> Hepatitis (What Type) _____ | | |

Please explain all checked conditions: _____

Client Health Questionnaire

Yes No Occasionally Do you suffer from constipation? How Long? _____
Yes No

Do other members in your family suffer from constipation? (Parents, siblings etc.) _____

Yes No

Do you suffer from diarrhea?

Do you suffer from alternating periods of constipation and diarrhea?

Do you suffer from hemorrhoids? (circle all that apply) Internal/ External / Both – Mild / Moderate / Sever

Have you ever had hemorrhoids surgically corrected? When? _____

Do you take laxatives? What type? _____ How often? _____

Do you take diuretics? What type? _____ How often? _____

Do you take fiber? What type? _____ How often? _____

Do you take stool softeners? What type? _____ How often? _____

Have you ever taken psyllium? When? _____

Do you strain to have a bowel movement?

How often do you have a bowel movement? _____

Colon hydro-therapy is a process, not a quick cure. Multiple sessions combined with good eating habits and regular exercise is necessary to achieve optimum results. It is advised before beginning diet, exercise, or complimentary modality, to discuss it with your physician.

I agree and understand the information presented to me. I declare the information I have disclosed herein to be true and accurate.

(Print Name)

(Signature)

(Date)

FOR OFFICIAL USE ONLY:
