Date:_____

Name: _____

Address: _____

City: _____ State: _____

Phone: (H)_____ (W): _____

Occupation: _____ Email: _____

Date of Birth: _____ Age: _____

Marital Status: _____ Sex: M F

Medications: _____

Allergies: _____

Supplements: _____

Do you use any of the following: Laxatives _____ Enemas_____ Antacids_____

Name of Physician:_____

Have you had surgery in the last year? _____

If yes, give details:_____

Have you been hospitalized in the last year?_____

If yes, give details:_____

Source of Referral:_____

How did you learn of Colon Hydro-Therapy treatment?_____

_____

Are these daily habits (Please list the Frequency)
Alcohol _____ Coffee_____
Tobacco _____ Exercise_____
Tea_____ Water _____
Carbonated Drinks_____ Sugar _____

How many hours sleep _____
Is appetite normal _____

Do any of the following apply?
__VEGETARIAN __CRAVING FOODS __DIETING __PRAYER / MEDITATION

What type of stress management do you use?
_____

Have you ever had a Colon Hydrotherapy treatment before? _____

How often have you undergone Colon Hydrotherapy treatment? _____

Were there any issues that arose in previous treatments that I should be aware of? _____
_____

Please put an "X" beside anything that is currently a health challenge for you.
Place a "P" for past problems and an "O" for occasional problems.

PROBLEMS:

__CONSTIPATION
__INDIGESTION
__ULCERS
__HEADACHES
__VISION PROBLEMS
__ALLERGIES
__INSOMNIA
__HYPOGLYCEMIA
__HEPATITIS
__PARKINSONS
__SWOLLEN GLANDS
__CYSTS/TUMORS
__BIRTH CONTROL PILLS
__FREQUENT_BURNING
__HIGH __LOW BLOOD PRESSURE
__DIARRHEA
__BELCHING
__COLITIS
__FATIGUE
__DIZZINESS
__PARASITES
__ANEMIA
__DIABETES
__HERPES
__CANCER
__GALL BLADDER
__INFECTIONS
__HEMMORHOIDS
__FLATULENCE/GAS
__ARTHRITIS
__BACK ACHES
__HEARING PROBLEMS
__YEAST INFECTIONS
__IRRITABILITY
__SINUS PROBLEMS
__EPILEPSY
__WATER RETENTION
__LIVER
__ANTIBIOTIC USE
__PROSTATE PROBLEMS
__DIFFICULTY URINATING
__BrBREAST IMPLANTS__YEAR

FREQUENCY OF BOWEL MOVEMENT:

__LESS THAN ONCE A WEEK
__ONCE A WEEK
__ABOUT EVERY__DAYS
__DAILY
__OTHER:_____
__SPONTANEOUS
__ ONLY AFTER EATING
__EFFORTLESS
__OFTEN REQUIRES STRAINING
__BLOOD IN STOOL

_____
Client Signature