Health Questionnaire

Name ________________________________ Today's Date ______________
Address ______________________________ City __________ ZIP __________
Telephone ______________ Cell # ____________ Date of Birth ____________
Age _____ Occupation ____________ E-mail ____________________

Have you ever had Colon Hydro Therapy (CHT) before? ______ If yes, when? ____________
Did you find CHT unpleasant in any way? (Explain) ______________________________
____
How did you learn of our services? ______________________________
Please state your reasons or expectations for having CHT: ____________________
____
Are you currently seeing a Health Care Provider? _____ If yes, please state reason for treatment: _____
____
____

Your Physicians name & phone number: ______________________________
Are you presently taking any medications? ____ If yes, please give details: ______________
____

Do you use & how often: Laxatives? ________ Antacids? ________ Enemas? _______
Detail any surgeries in the last year: ______________________________
____
Detail any hospitalizations in the last year: ______________________________
____
Have you ever had a Barium Enema? _____ If yes, when and what results? ______________
____
Detail all allergies: ______________________________
List the year & type of any operations or major illness: ______________________
____
____

Normally, how many times a day do you eliminate? (Bowel Movements) ______________

Have you ever heard of "Food Combining"? ______ If yes, do you use this in your diet? ______
How many glasses of water do you drink each day? _____ How much soda? ____ Coffee? ____
What are your sources of food fiber? ______________________________
____
Do you eat acidophilus? _____ Type & quantity? ______________________
Do you eat dairy products? _____ If yes, how often? ______________________
Do you take diuretics? ___ What type? ________ Do you exercise? ____ How often? _____

Do you have hemorrhoids? ____ If yes, do you consider them a problem? ______________
Do you have rectal problems? _____ If yes, please explain: ______________________
____

Do you ever experience rectal bleeding? ___ If yes, when or why? ____________________
____
____
Signature ________________________________ Today's Date: ____________
No refunds on series or programs balance may be used on other services. x____________
Please give 48 hour notice to cancel or reschedule an appointment. x____________

 Continued on next page —-

Health Questionnaire • For Current —- √ For Past

- ☺ Severe Anemia
- ☺ Severe Hemorrhoids
- ☺ Congestive Heart Failure
- ☺ Cancer of Colon or GI Tract
- ☺ GI Hemorrhage or Perforation
- ☺ Epilepsy or psychoses
- ☺ Uncontrolled Hypertension
- ☺ Fissures or Fistulas
- ☺ Abdominal hernia or acute pain
- ☺ History of Seizures
- ☺ General debilitation
- ☺ Pregnancy
- ☺ Organic Valve Disease
- ☺ Cirrhosis
- ☺ Colon or Rectal Surgery
- ☺ Kidney Insufficiency
- ☺ Diverticulitis

- ☺ Crohn's Disease
- ☺ Ileitis
- ☺ Family History-Colon Cancer
- ☺ Regional Enteritis
- ☺ Colitis
- ☺ Rectal Bleeding

- ☺ Headaches
- ☺ Insomnia
- ☺ Weight Loss
- ☺ Dizziness
- ☺ Fainting Spells
- ☺ History of Seizures
- ☺ Fatigue
- ☺ Double/Blurred Vision
- ☺ Rectal Bleeding
- ☺ Bursitis
- ☺ Swollen Joints
- ☺ Rapid Heart Beat
- ☺ Eat When Nervous
- ☺ Cold Sweats Often
- ☺ Difficulty Remembering
- ☺ Sneezing Attacks
- ☺ Pain Between Shoulder Blades
- ☺ Noises in Head or Ears
- ☺ Afternoon Headaches
- ☺ Bad Breath (Halitosis)
- ☺ Hot-Burning Feet
- ☺ Sigh Frequently
- ☺ Extremities Cold or Clammy
- ☺ Heart Pounds after Retiring
- ☺ Indigestion
- ☺ Milk Products Distress
- ☺ Stomach Bloating after Meal
- ☺ Digestion Difficult
- ☺ Vomit Frequently
- ☺ B M Painful & Difficult
- ☺ Joint Stiffness on Arising
- ☺ Frequent Urination
- ☺ Itching Feet
- ☺ Irregular Cycles (Women)
- ☺ Date of Last Period (Women)
- ☺ Painful Cycles
- ☺ Shortness of Breath
- ☺ Constipation
- ☺ Vomiting Blood
- ☺ Ulcerative Colitis
- ☺ Bronchitis
- ☺ Diverticulosis
- ☺ Gall Bladder Disease
- ☺ Enlarged Thyroid
- ☺ Cancer
- ☺ Low Back Pain
- ☺ Hardening of the Arteries
- ☺ Skin Rash
- ☺ History: Gall Bladder Problems
- ☺ Kidney Infections or Stones
- ☺ Dry Mouth, Eyes, Nose
- ☺ Bitter, Metallic Taste in Mouth
- ☺ Worried, Insecure
- ☺ Frequent Nosebleeds
- ☺ Keyed Up
- ☺ Get Drowsy Often
- ☺ Crave Candy or Coffee
- ☺ Angina-Chest Pain
- ☺ Perspire Easily
- ☺ Greasy Foods Upset
- ☺ Coated Tongue
- ☺ Irregular Breathing
- ☺ Dull Pain in Chest/Left Arm
- ☺ Tension Under Ribcage
- ☺ Constipation/Diarrhea Alternating
- ☺ Muscle Cramps at Night
- ☺ Excessive Appetite
- ☺ Mucous Colitis
- ☺ Swollen Ankles
- ☺ Burning or Itching Anus
- ☺ Change in stool
- ☺ Blood in Stool
- ☺ Chronic Cough
- ☺ Prostate Problems
- ☺ Emphysema
- ☺ Bruise Easily
- ☺ Asthma—Wheezing
- ☺ Burning in Stomach
- ☺ "Floaties" in front of eyes
- ☺ Arthritis
- ☺ Neck Pain
- ☺ Skin Dryness
- ☺ Poor Circulation
- ☺ Irregular Heart Beat
- ☺ Hair Loss
- ☺ Eyes Swollen, Puffy
- ☺ Depression
- ☺ Irritable Before Meals
- ☺ Bad Dreams or Nighmares
- ☺ Susceptible to Colds—Flu
- ☺ Can't Get to Sleep
- ☺ Fever Easily Raised
- ☺ Pressure in Pit of Stomach
- ☺ Acid Foods Upset
- ☺ Skin Itching
- ☺ Difficulty Swallowing
- ☺ Sour Stomach
- ☺ Gag Easily
- ☺ Gas Shortly after Eating
- ☺ Appetite Reduced
- ☺ Stool has Foul Odor
- ☺ Loss of Leg Energy
- ☺ Neuralgia-like Pain
- ☺ Painful Urination
- ☺ Other: (Be Specific)

____

____

Signature ______________________________ Date ________________

Continued next page —

Please read this list carefully. Ask any questions you may have.

Circle any conditions you may have:

Uncontrolled Hypertension	**Severe Cardiac Disease**	**Congestive Heart Failure**
Vascular Aneurysm	**Organic Valve Disease**	**Abdominal Hernia or Surgery**
Colon or Rectal Surgery	**Severe Anemia**	**Cancer of the Colon or Rectum**
Cirrhosis	**Fissure or Fistulas**	**Renal (kidney) Insufficiency**
Pregnancy	**GI (gastrointestinal) Hemorrhage/Perforation**	
Recent Heart Attack	**General Debilitation**	**Epilepsy or Psychoses**
History of Seizures	**Diverticulitis**	

To my knowledge, I have none of these diseases or health conditions. I have been advised that if I think or feel that I **might** have any of these health problems, I should immediately be examined by a qualified medical doctor and **NOT HAVE COLON HYDROTHERAPY.**
I am aware that colon hydrotherapy has not been clinically tested to provide ANY medical benefits. I further understand that the provider of these services is **NOT** a medical provider. I understand that disclosure of any of the conditions listed above is essential in providing safe colon hydrotherapy. I expressly give my permission for this colon hydro therapist to provide me with this service.

My initials _____________

I am here because: _______ doctor advise/prescription ______ self treating

I also understand that a ***24 cancellation notice*** is respectfully required. I understand that cancellations ***less than 24 hours will be billed at regular appointment charges.***

My initials ______________

If you are a **State, Federal or Local Agent** upon entering these premises **YOU MUST DECLARE SAME** or under the BIVENS ACT—ARTICLE 42 — be held personally and individually liable.

My initials _______________

Emergency contact person ______________________________ Phone __________________

I have carefully read and understand all the above information. My signature below and my initials above indicate that ***I agree*** with all of the above statements.

Signature ____ Date _________________