

# Client Health Questionnaire

## CONTACT INFORMATION

Name: \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell)

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)

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, please explain where & when.

How did you learn of our services? \_\_\_\_\_

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

# Client Health Questionnaire

## **FOR WOMEN ONLY**

Yes No Yes No  
\_\_\_ \_\_\_ Are you pregnant? \_\_\_ \_\_\_ Is there a chance you may be pregnant?  
\_\_\_ \_\_\_ Are your periods regular? \_\_\_ \_\_\_ Do you suffer from PMS?  
\_\_\_ \_\_\_ Do you take birth control Pills? \_\_\_ \_\_\_ Do you take Hormone supplements?

## **FOR MEN ONLY**

Yes No  
\_\_\_ \_\_\_ Do you have difficulty urinating?  
\_\_\_ \_\_\_ Do you take Hormone supplements?  
\_\_\_ \_\_\_ Are you experiencing ED difficulties?  
Date of last Colonoscopy \_\_\_\_\_

Please explain all yes answers: \_\_\_\_\_

## **DAILY HABITS**

What is a typical:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snack \_\_\_\_\_

Daily Water Consumption \_\_\_\_\_

Beverages \_\_\_\_\_

Alcohol \_\_\_\_\_ what & 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 of 1-5 (with 1 being low and 5 being very high) what best describes your usual daily stress level 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?

**VITAL HEALTH INFORMATION**

In order to provide the best possible care and to insure optimum results from your colon hydrotherapy 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 of all known allergies \_\_\_\_\_  
\_\_\_\_\_

List the type and year of all surgeries and major illnesses \_\_\_\_\_  
\_\_\_\_\_

Have you ever had? (if yes, when)

Colonoscopy     Signoidoscopy     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/Perforation |  | <input type="checkbox"/> Cirrhosis             |  |
| <input type="checkbox"/> Abdominal Hernia          | <input type="checkbox"/> Aneurysm            | <input type="checkbox"/> Hepatitis (what type) |  |
| <input type="checkbox"/> HIV                       | <input type="checkbox"/> AIDS                |  |  |

Please explain all checked conditions \_\_\_\_\_  
\_\_\_\_\_

## Client Health Questionnaire

Yes  No  Occasionally Do you suffer from constipation? How long? \_\_\_\_\_

Yes  No Do other members of your family suffer from constipation? \_\_\_\_\_

Yes No

Do you suffer from diarrhea?

Do you suffer from alternating periods of constipation and diarrhea?

Do you suffer from hemorrhoids? Internal / External / Both – Mild / Moderate / Sever

Have you ever had hemorrhoids surgically corrected? When \_\_\_\_\_

Do you take laxatives? What type? \_\_\_\_\_ How often \_\_\_\_\_

Do you 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 bowl 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:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_