



### Client Health History

Please print and answer all questions: Date: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Email \_\_\_\_\_

Who should we thank for referring you? \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Please mark (x) if you have had or currently have any of the following:

- |   |   |
|---|---|
| <input type="checkbox"/> Alcoholic              | <input type="checkbox"/> Frequent burping         |
| <input type="checkbox"/> Allergies              | <input type="checkbox"/> Gas - foul odor          |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Greasy food upset        |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Hemorrhoids              |
| <input type="checkbox"/> Bad breath             | <input type="checkbox"/> High blood pressure      |
| <input type="checkbox"/> Barium enema           | <input type="checkbox"/> Hungry between meals     |
| <input type="checkbox"/> Blood clots            | <input type="checkbox"/> Indigestion              |
| <input type="checkbox"/> Blood in stool         | <input type="checkbox"/> Infectious disease       |
| <input type="checkbox"/> BM painful/difficult   | <input type="checkbox"/> Intestinal toxemia       |
| <input type="checkbox"/> Bronchitis             | <input type="checkbox"/> Irritability             |
| <input type="checkbox"/> Burning / itching anus | <input type="checkbox"/> Laxatives used often     |
| <input type="checkbox"/> Burning stomach        | <input type="checkbox"/> Malignant condition      |
| <input type="checkbox"/> Bursitis               | <input type="checkbox"/> Migraine headaches       |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Parasitic infections     |
| <input type="checkbox"/> Chronic fatigue        | <input type="checkbox"/> Recent Accident /Surgery |
| <input type="checkbox"/> Circulatory            | <input type="checkbox"/> Respiratory              |
| <input type="checkbox"/> Coated tongue          | <input type="checkbox"/> Skin problems            |
| <input type="checkbox"/> Colonoscopy            | <input type="checkbox"/> Sour stomach             |
| <input type="checkbox"/> Constipation           | <input type="checkbox"/> Spinal injuries          |
| <input type="checkbox"/> Cramping               | <input type="checkbox"/> Stool - foul odor        |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Survivor                 |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Swollen ankles           |
| <input type="checkbox"/> Difficulty sleeping    | <input type="checkbox"/> TB                       |
| <input type="checkbox"/> Digestive problems     | <input type="checkbox"/> Ulcers                   |
| <input type="checkbox"/> Diverticulosis         | <input type="checkbox"/> Varicose veins           |
| <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Vomiting                 |
| <input type="checkbox"/> Extreme stress         | <input type="checkbox"/> Worried / Insecure       |

How often do you have a bowel movement?

- 2-3 times a day                       Once per day                       4-5 times per week
- 2-3 times per week                       Once per week                       Other

Contraindications: (If you have been diagnosed with any of the following, you may not be able to proceed with the colon hydrotherapy session.)

- |  |  |
|--|--|
| <input type="checkbox"/> Abdominal hernia                    | <input type="checkbox"/> Crohns disease                      |
| <input type="checkbox"/> Abdominal surgery (within 6 months) | <input type="checkbox"/> Intestinal perforations             |
| <input type="checkbox"/> Abdominal distension                | <input type="checkbox"/> Pregnancy (due date _____)          |
| <input type="checkbox"/> Acute liver failure or Cirrhosis    | <input type="checkbox"/> Recent childbirth (within 6 months) |
| <input type="checkbox"/> Anal fissures or fistulas           | <input type="checkbox"/> Rectal bleeding                     |
| <input type="checkbox"/> Anemia                              | <input type="checkbox"/> Renal failure                       |
| <input type="checkbox"/> Aneurism                            | <input type="checkbox"/> Severe cardiac condition            |
| <input type="checkbox"/> Colon cancer or colon surgery       | <input type="checkbox"/> Ulcerative colitis                  |
| <input type="checkbox"/> Taking colon thinning medication    | <input type="checkbox"/> Uncontrolled high blood pressure    |

Please list any medications that you are currently using:

\_\_\_\_\_

Why have you chosen to have colon hydrotherapy?

- 9th amendment right to self-prescribe                       Doctor referral

Other: \_\_\_\_\_

Are you currently under a doctor's care?  If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you consulted with your physician regarding your receiving colon hydrotherapy? \_\_\_\_\_

If yes, what is your physician's name, opinion, and instructions regarding your colon hydrotherapy session? \_\_\_\_\_

\_\_\_\_\_

Is there any other health history that we should know? \_\_\_\_\_

\_\_\_\_\_

In case of emergency call: \_\_\_\_\_ Phone: \_\_\_\_\_

All the information that I have given is true. I am aware that the colon hydrotherapists are not physicians and therefore make no claims to treat or cure disease. I also understand that the colon hydrotherapist does not insert anything into my body. I am responsible for my own insertion of the rectal tube and I will stop my session and notify the therapist immediately should I experience any discomfort.

Signature \_\_\_\_\_ Date \_\_\_\_\_