



COLON HYDROTHERAPY HEALTH QUESTIONNAIRE

Patient _____ Today's Date _____

Address _____

City _____ State _____ Zip code _____

Sex: Male Female Age _____ Birthdate ___/___/___ Marital Status _____

Email _____ Occupation _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home _____ Work _____ Ext _____ Cell _____

In case of emergency, contact: Name _____ Relationship _____

Home Phone _____ Work Phone _____

Allergies: _____

Supplements: _____

Have you ever had colon therapy before? Yes No How many treatments? _____

If Yes, when and where? _____

Do you use any of the following? Laxatives Enemas Antacids

Are you presently taking any medications? Yes No If yes, give details:

Have you ever had surgery? Yes No If yes, give details:

Have you been hospitalized in the last year? Yes No If yes, give details:

Do you have any contagious diseases now? Yes No Please list all:

Do you have history of colon cancer in your family? Yes No

Are you pregnant? Yes No Your physician's name and address:

Please briefly describe reasons you are choosing colon hydrotherapy:

- Constipation Bloating Gas Pain Diarrhea Colitis Cleansing Illness
 Other: _____

How often do you have a bowel movement? _____ Last time you had a BM? _____

Please check those that apply to you below:

GENERAL

- Headaches
 Insomnia (loss of sleep)
 Loss of weight
 Dizziness
 Fainting spells
 History of seizures
 Fatigue
 Depression
 Enlarged thyroid
 Double/blurred vision
 Other: _____

MUSCLE AND JOINT

- Arthritis
 Bursitis
 Lower back pain
 Neck pain
 Other pain: _____

GENITO-URINARY

- Kidney infection or kidney stone
 Painful urination
 Prostate troubles
 Kidney failure

GASTRO-INTESTINAL

- Colitis
 Constipation
 Chrohn's disease
 Ulcerative colitis
 Diverticulitis
 Gall bladder disease
 Hemorrhoids
 Fissures/fistulas
 Liver trouble
 Cirrhosis
 Rectal bleeding
 Vomiting blood
 Cancer
 Family history of colon cancer

CARDIOVASCULAR

- High blood pressure
 Hardening arteries
 Angina (chest pain)
 Poor circulation
 Rapid heart beat
 Irregular heart beat
 Congestive heart failure
 Swelling of Ankles

SKIN

- Bruise easily
 Dryness
 Itching
 Rash

RESPIRATORY

- Shortness of breath
 Chronic Cough
 Emphysema
 Bronchitis
 Asthma (wheezing)

WOMEN

- Painful menstruation
 Vaginal discharge
 Breast pain
 Pregnant
Las menstrual period: _____