COLON HYDRO HEALING

CASE HISTORY FORM

Date	YYYY / MM / DD

Name		DOB	Gender	Who Referred You?
Surname	Given	YYYY / MM / DD	☐ Male ☐ Female	
Address			**Contact Information**	
Suite # Street City Province Postal			☐ Residence	( ) -
			☐ Cell	( ) -
			☐ Email	

Emergency Contact Information			Number
Surname	Given	Relationship	( ) -

Health History	
Have you had Colon Hydrotherapy treatments previously	☐ Yes ☐ No
How many?	

Health History (PLEASE CHECK THE CONDITIONS THAT YOU ARE EXPERIENCING)

Head & Neck ☐ Headache ☐ Earache ☐ Sinus Problem ☐ Allergies ☐ Frequent Colds ☐ Vision Problems	**Muscles & Joints** ☐ Pain ☐ Stiffness ☐ Swelling ☐ Back Pain ☐ Shoulder Pain ☐ Arthritis	**Skin** ☐ Sensitive Skin ☐ Rashes/Eruptions ☐ Herpes/Aids ☐ Varicose Veins ☐ Bruising
Respiratory ☐ Asthma ☐ Shortness of Breath ☐ Chronic Cough ☐ Smoking	**Cardiovascular** ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Poor Circulation ☐ Heart Problems	**Women** ☐ PMS Problems ☐ Menopause ☐ Pregnant
Uro-Genital ☐ Kidney/Bladder ☐ Overy/Uterus ☐ Prostrate	**Other** ☐ _____ ☐ _____ ☐ _____	**Cancer/Type/When** _____ _____ _____

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Digestive Disorders

☐ Anemia	☐ Difficult Digestion	☐ Laxative Use
☐ Appendicitis	☐ Eating Disorder	☐ Liver/Gallbladder
☐ Bad Breath	☐ Gas/Bloating	☐ Parasites
☐ Cholesterol	☐ Heartburn	☐ Poor Appetite
☐ Constipation	☐ Hemorrhoids	☐ Spastic Colon
☐ Crohn's Disease/Colitis	☐ Hiatus Hernia	☐ Stomach
☐ Diabetes	☐ Hypoglycemic	☐ Thyroid Problem
☐ Diarrhea	☐ Irritable Bowel	☐ Yeast

Energy Level	
Energy Level	☐ Poor ☐ Up & Down ☐ Good ☐ Very Good
Sleeping Habits	☐ Poor ☐ Good ☐ Very Good

Energy Level	
Number of bowel movement daily	
List present medications/supplements	
Have you taken antibiotics for over a month?	☐ Yes ☐ No If yes, when:
List dates of surgeries (minor or major)	
Do you have any health concerns?	
Are you being treated for any diagnosed medical conditions at this point?	
What allergies or food restrictions/sensitivities do you have?	
On a scale of 1 to 10, what is your stress level?	**1 2 3 4 5 6 7 8 9 10**

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Diet & Lifestyle					
Vegetarian? ☐ Yes ☐ No	If yes, how many years?			☐ Eggs & Dairy	☐ Vegan
Frequency of Consumptions:	Poultry/Fish:	Red Meat:	Dairy:	Eggs:	
Flour Products/Breads:	Caffeine:	Sugar:	Salt:	Artificial Sweeteners:	
Soft Drinks:	Alcohol:				
What is your water intake per day?	Cups per day				
Do you follow food combining rules?					

Colon Hydrotherapy is an effective method of cleansing the colon. It is my personal choice and responsibility to receive Colon Hydrotherapy to cleanse the lower bowel.

Print Name: _____

Clients Signature: _____

Date: _____