HEALTH QUESTIONNAIRE

Name: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Work) _____

Occupation: _____ Date of Birth: _____

Height: _____ Weight: _____ Marital Status: _____ M/F: _____

Supplements: _____

Allergies: _____

- Have you ever had Colon Hydrotherapy before? _____
- If Yes, when and where? _____ How many? _____
- Do you use any of the following?:

  Laxative _____ Enemas _____ Antacids _____
- Are you presently taking any medications? _____ If yes, give details:

_____

_____

- What if any diseases or disorders have you been diagnosed with from a medical or nautropathic doctor?

_____

- Have you ever had surgery? Please give details and dates:

_____

_____

- Have you been hospitalized in the last year? _____ If yes, give details:

_____

- Do you have any contagious diseases now? _____ Please describe:

_____

- Do you have a history of colon Cancer in your family? _____ Are you pregnant? _____

Your Physician's name and address:

_____

Please briefly describe reasons you are choosing Colon Hydrotherapy: _____

_____

____ Constipation ____ Bloating ____ Gas Pain ____ Diarrhea ____ Colitis ____ Cleansing ____ Illness

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

SOURCE OF REFERRAL: _____

AGREEMENT (Please read and Sign)

The practitioner giving me a Colon Hydrotherapy Treatment does not provide medical services of any kind. Clients are expected to seek and use such medical services as may be required from a physician. The service of Colon Hydrotherapy is not designed to diagnose, treat or cure any disease or medical condition. Any medication, or other supplementation prescribed by your physician should be continued.

I agree that I have read and understood the above statement. All the information given by me, the client, here is true.

CLIENT'S SIGNATURE _____ DATE: _____