HEALTH INTAKE FORM

Name *

Phone *

Email *

Address *

Street Address

Apt, Suite, Bldg. (optional)

City

State / Province / Region

Postal / Zip Code

Country

How were you referred here? *

Occupation *

How Long? *

Age *

Height *

Weight *

Birthday *

Reason for visit: *

Please check if you have ever had any of the following:

- Cancer (where/when)
- Severe Cardiac Disease
- Severe Anemia
- Severe Hemorrhoids
- Fissures/Fistuals (colon)
- Recent Colon Surgery
- Crohn's Disease/Colitis/Diverticulitis
- Aneurysm
- GI Hemorrhage/Perforation
- Cirrhosis
- Abdominal Hernia
- Renal (Kidney) Insufficiency

List Surgeries (When/What)

List Current Medications & Supplements:

Please list the name and for what reason.

In case of and emergency, whom should we call? *

Please list the name, phone number and relationship.

Is there anything else that we should know about you?

Have you been diagnosed with any illness like diabetes, arthritis, heart trouble, circulatory, respiratory, etc? *

PLEASE CHECK if you currently do/have:

- Use Alcohol
- High Cholesterol
- Burning Stomach
- Constipation
- Swollen Ankles
- Chronic Stress
- Asthma/Bronchitis/Upper Respiratory
- BM Painful/Difficult
- Bloating
- Other
- Chronic Depression
- High Blood Sugar
- Burning/Itching Anus
- Laxative Use
- Difficulty Sleeping
- Allergies
- Arthritis
- Indigestion/Heartburn
- Skin Problems
- High Blood Pressure
- Chronic Fatigue
- Coated Tongue
- Diarrhea
- Smoke
- Headaches
- Gas with foul odor
- Vomiting
- Other

Bowel Movement Frequency *

- One or more times per day
- Two - Three times per week
- Once per week
- Two - Three times per month

Do you use laxatives? If so how often? *

Do you strain? *

- Yes
- No

Rectal Bleeding? *

- Yes
- No

Hemorrhoids? *

- Yes
- No

Do you use fiber? What Kind? *

Ever had:

- Barium Enema
- Colonoscopy
- Colon Surgery
- Rectal Surgery

If you have had any of the above what year?

How often do you consume the following foods per week?

Protein w/ Starches @ Meals (i.e. meat w/ potatoes and/or bread)

White Flour Products (bread, cakes, etc.)

Fast Food

Restaurants

Packaged Dinners

Red Meat

Late Night Snacks

Soft Drinks

Fish

Milk

Cheese

Sugar Free/Fat Free Products

Multi-Grain Products/Cereal

Fresh Fruit (Raw)

Fresh Vegetables (Raw)

Canned Fruits/Vegetables

Coffee/Tea

Bottled Water

How often do you exercise?

Daily

Type of exercise

- [ ] Walking, casual
- [ ] Walking, power
- [ ] Jogging/Running
- [ ] Aerobics
- [ ] Weight Bearing/gym work
- [ ] Yoga/Stretching

What measures do you take to reduce stress?

- [ ] Exercise/Sports
- [ ] Hobbies
- [ ] Recreational Activities
- [ ] Supplements/Prescriptions
- [ ] Spiritual/Mental Work
- [ ] Meditation
- [ ] Reading/Writing
- [ ] Performing Arts

Have you ever done any cleansing, fasting or detoxing before? *

- ( ) Yes
- ( ) No

Any mind/body connective work? *

- ( ) Yes
- ( ) No

What are your health goals?

Aside from your primary care physician

Do you want health & nutritional advice?

- Yes
- No

Is weight management an issue with you?

- Yes
- No

Do you want to lower your cholesterol?

- Yes
- No

Do you need help with stress management?

- Yes
- No

Are there any other targeted areas of health you want assistance with, that you are not otherwise getting from your medical doctor?

Why have you chosen to have Colon Hydrotherapy, Health and Nutritional Counseling? (Check one)

- 9th Amendment Right to Self Prescribe
- Doctor Referral

Please list who referred you?

Do you have insurance? If yes, with whom? *

If you are interested in filing, please ask for details.

Are you currently under a doctors care? Whom? *

What are you being treated for?

If you are Federal, State or Local Agent upon entering YOU MUST DECLARE same or under THE BIVENS ACT - ARTICLE 42 OR BE HELD PERSONALLY & INDIVIDUALLY LIABLE

Please PRINT this form and bring it in with you to your appointment.