Health Questionnaire

Name_____Date_____

Address_____City_____State_____Zip_____

Telephone (Circle preferred) Home_____ Work_____ Cell_____

Email_____ Referred By_____

Is this your first colonic? _____ If no, when?_____

Height_____ Weight_____ Birth Date_____ Marital Status _____Male __Female__

Are you currently under a medical doctor's care:_____ Explain_____
_____

Doctor's Name_____ Dr.'s Telephone #_____

Emergency contact information_____

Are you pregnant?_____ Childbirth history_____

List all known allergies_____

List all surgeries_____

List all medications_____

List all supplements_____

Please put an "**X**" beside anything that is currently a health challenge. Put a "**P**" beside a past problem.

__Constipation
__Hemorrhoids
__Indigestion
__Belching
__Flatulence/gas
__Ulcers
__Colitis
__Arthritis
__Headaches
__Fatigue
__Back aches
__Vision problems
__Dizziness
__Acid reflux

__Allergies
__Yeast infections
__Insomnia
__Anemia
__Irritability
__Hypoglycemia
__Diabetes
__Sinus problems
__Hepatitis
__Herpes
__Asthma
__Parkinson's
__Cancer
__Hiatal hernia

__Gall bladder
__Impaired hearing
__Cysts/tumors
__Infections
__Antibiotic use
__Birth control pills
__Prostate problems
__Urination problems
__Blood pressure
__Breast implants
__Pregnancies
__Psyche disorders
__Water retention
__Difficult menstruation

Explain_____
_____
_____

Bowel Habits

How often do you have a bowel movement_____ What time of day_____

Are they (Circle): Spontaneous? Only after eating? Requires straining? Effortless?

Do you have hemorrhoids or other rectal problems?_____

How often do you use a laxative_____ Herbal laxative_____ Stool Softener_____

Suppositories_____ Enemas_____

Have you ever had rectal bleeding?_____ If yes, when_____

Mark a "Y" for yes and an "N" for no. If yes, list amount and frequency.

__coffee_____
__diet programs_____
__tea_____
__vegetarian/vegan_____
__carbonated drinks_____
__exercise (type & frequency)_____
__alcohol_____
__hours sleeping_____
__tobacco_____
__stress mgmt. (type)_____
__sugar/salt cravings_____
__dairy products_____
__plain water intake per day_____
Source of water_____

HOW MANY MERCURY FILLINGS DO YOU HAVE IN YOUR TEETH? _____

HOW MANY ROOT CANALS? _____ WHEN? _____

Any family history of digestive problems, cancer, heart disease? _____

What do you hope to achieve from this appointment?_____
_____

Signature_____Date_____

FULL CHARGE FOR LESS THAN 24 HOURS NOTICE
TO CHANGE OR CANCEL APPOINTMENT