[illegible] THERAPIES

Glenwood Springs

970-618-2492

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____

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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