Colon Hydrotherapy Holistic Questionnaire

NAME:_____

Phone: _____ Address: _____

You **MUST** check **YES** or **NO** for each of the following and indicate any **ACTIVE (A)** CONTRAINDICATIONS:

	Y	N	A		Y	N	A		Y	N	A		Y	N	A
1st Trimester of Pregnancy				Cancer				Fissures/Fistulas				Severe Cardiac Disease			
Abdominal Hernia				Chemo/radiation treatment				GI Hemorrhage/ Perforation				Severe Diverticulitis			
Advanced Pregnancy				Cirrhosis				Renal Insufficiency				Severe Hemorrhoids			
AIDS/HIV				Colon Surgeries				Severe Anemia				Ulcerated Colitis			
Aneurysm				Crohn's Disease											

PLEASE EXPLAIN & INDICATE DATES OF DIAGNOSIS_____

THE FOLLOWING IS **OPTIONAL**, BUT IT HELPS THE THERAPIST TO PREPARE A BETTER SESSION FOR YOU:

PLEASE INITIAL SHOULD YOU CHOOSE NOT TO ANSWER _____

1.OCCASIONAL/MILD SYMPTOM 2.FREQUENT/MODERATE SYMPTOM 3.SEVERE/CONSTANT SYMPTOM OR 'NO' IF NOT APPLICABLE

HEALTH HISTORY	NO	#	HEALTH HISTORY	NO	#	HEALTH HISTORY	NO	#
Allergies			Diabetes			Lung disorders		
Allergies drug reaction			Digestive Problems			Lupus		
Anemia			Diverticulosis			Painful Menstruation		
Anorexia/ Bulimia			Dizziness			Date of last menstrual cycle		
Arthritis			Double/blurred vision			Vaginal discharge		
Asthma			Earache			Breast Pain		
Back problems/pain			Edema/ swelling			Muscle / Joint pain		
Bad breath			Excess Gas			Muscle Stiffness		
Bitter metallic taste			Excessive hair loss			Neuropathy		
Bladder disorders			Fatigue			Organ Transplant		
Bladder infection			Frequent colds			Pacemaker		
Bronchitis			Headaches			Poor appetite		
Burping			Heart-burn/ acid reflux			Prostate problem		
Chronic cough			HEP-C / HIV / Aids			Seizures		
Chronic fatigue			Hemorrhoids			Sinus Problems		
Colitis			High/low blood pressure			Skin disease		
Cold Sores			Insomnia			Uterus disorder		
Constipation			Irritable bowel (IBS)			Uterus/ Ovary problems		
Depression			Liver disorders			Organ Transplant		

THE FOLLOWING IS **OPTIONAL**, BUT HELPFUL:

What are you expecting to receive from this appointment?

Is there anything specific you would like to work on during the session? What are your long-range goals?

_____

_____

Are you allergic to COCONUT OIL? _____ Yes _____ No _____ Not Sure

I've been informed & agree to self-insertion & self- retraction of the speculum INITIAL _____

Have you ever had a colonic before? If yes, when was your last session _____

How many bowel movements per day do you usually have? _____

Do you strain to have a bowel movement? _____

Do you use a stool softener or laxative? _____

Herbal laxative? _____

Suppository? _____

Do you have hemorrhoids or other rectal problems?_____

Have you ever had bleeding from colitis or any bodily orifice _____

Have you ever had a barium enema? If so, when? _____

Have you ever had a colonoscopy? If so, when _____

How much water do you drink per day? _____

Are you always hungry/never hungry or eat when nervous? _____

Do you have reactions when meals are delayed? _____

Do you crave any foods? *If YES give details:* _____

Please read all above carefully before signing:

"The purpose of Newlistic Wellness center is to provide services, products and offer information to clients. Our services, products and information are for vocational and avocational self-improvement. We do not intend to treat, diagnose, prescribe or cure. All procedures are directed towards the establishment of this goal."

Because you must be aware of any existing physical conditions that I may have, I have honestly answered all above questions and am not intentionally withholding information about my health. I will inform Newlistic Wellness center of any changes in my physical health. I am agreeing to the office policies and procedures of Newlistic Wellness Center.

Client's Signature: _____ Date: _____