Alternative Health Center of Cary

A HEALTHIER LIFE...NATURALLY

CLIENT HISTORY
Colon Therapy

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

E-mail Address _____

Phone: Home _____ Business _____

Occupation _____ Birthdate _____

Height _____ Weight _____ Male/Female _____

Marital Status _____ Glasses/Contacts _____

Blood Pressure _____ Normal Body Temperature _____

This information will help us meet your individual needs. Thank you for your cooperation.

Please describe your primary complaint: _____

_____

_____

Referred By _____

IT IS IMPORTANT to have a thorough understanding of your past and present physical condition to provide you with a quality health care program. Take your time and check any of the following you **HAVE** had. **UNDERLINE ANY YOU CURRENTLY HAVE.**

GASTROINTESTINAL

- ☐ recent constipation
- ☐ chronic constipation
- ☐ diarrhea
- ☐ intestinal worms
- ☐ colitis
- ☐ diverticulitis
- ☐ bowel impactions
- ☐ hemmorrhoids
- ☐ appendicitis
- ☐ bloody or black stools
- ☐ fistula or fissures
- ☐ ulcers
- ☐ hernia
- ☐ Chrohn's Disease
- ☐ recurrent abdominal pain
- ☐ vomiting
- ☐ persistent change in stool
- ☐ protruding, sagging, tender stomach
- ☐ gas, belching or flatulence

METABOLIC

- ☐ underweight
- ☐ overweight
- ☐ diabetes
- ☐ low blood sugar
- ☐ high cholesterol
- ☐ frequent heart burn
- ☐ obesity

MUSCULOSKELETAL

- ☐ painful joints
- ☐ leg or muscle cramps
- ☐ muscle pain
- ☐ recent accident

CONTAGIOUS DISEASE

- ☐ Epstein Barr Virus
- ☐ HIV
- ☐ Mononucleosis
- ☐ Herpes
- ☐ Hepatitis

GENERAL

- ☐ heart disease
- ☐ cancer
- ☐ skin sores
- ☐ body odors
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ frequent headaches
- ☐ migraine headaches
- ☐ nervousness, anxiety
- ☐ insomnia
- ☐ irritability
- ☐ anemia
- ☐ arthritis
- ☐ menstrual problems
- ☐ prostate trouble
- ☐ fatigue
- ☐ epilepsy
- ☐ skin disorders
- ☐ pregnant
- ☐ nursing

Are you on a nutritional diet program? _____ Yes _____ No

Are you taking vitamins and minerals? _____ Yes _____ No

Please list the supplements you are taking:

1 _____ 7 _____

2 _____ 8 _____

3 _____ 9 _____

4 _____ 10 _____

5 _____ 11 _____

6 _____ 12 _____

Have you had a...

1 Barium Enema	_____ Yes	_____ No	_____ Year
2 Blood Test	_____ Yes	_____ No	_____ Year
3 Hair Analysis	_____ Yes	_____ No	_____ Year
4 Urine Analysis	_____ Yes	_____ No	_____ Year
5 Colon Scope	_____ Yes	_____ No	_____ Year

Please List:

1 Surgeries **Date**

_____

_____

_____

_____

2 Medications you are currently taking:

_____

_____

_____

_____

3 Allergies:

_____

_____

_____

_____

4 **Habits**

	How much?		How much?		How Often?
Coffee	_____	Alcohol	_____	Exercise	_____
Tea	_____	Drugs - Medication	_____	Rest	_____
Soda Pop	_____	Drugs - Recreation	_____	Meditation	_____
Tobacco	_____	Anxiety	_____	Stress Release	_____
Sugar	_____	Dieting	_____		

Frequency of Bowel Movements:

____ Less than once a week
____ Once a week
____ About every ____ Days
____ Daily
____ Twice Daily
____ Other, Describe

Occurance Of Bowel Movements:

____ Spontaneous
____ Only After eating Something
____ Effortless
____ Often Requires Straining
____ Painful
____ Blood in stool

Use of Laxative:

____ Frequent
____ Occasional
____ Never

Type of laxative used:

_____

____ Enema

NOTES

- I understand that treatments are given by licensed colonic therapists.
- I have listed all my known medical conditions and physical limitations, and I will inform the therapist of any changes in my physical health.
- I agree that all services rendered to me are charged directly to me and I am responsible for payment unless prior arrangements have been made.
- I agree to pay for all scheduled appointments that I am unable to keep unless I notify the clinic at least 24 hours in advance.

Signature: _____ Date: _____

Feel free to ask your therapist any questions you have