Patient Information - Colonic Irrigation Therapy

Name: _____ Date of Birth: ____/____/_____
Occupation: _____ Phone: _____
Email: _____
How did you find us? _____

Are you currently under doctor's care? Yes/No If so, why? _____
Do you take any medication, if so which ones? _____
_____

Allergies: What type? _____
Cancer: What type? _____
Surgeries: Which one and when? _____
_____
Last X-rays? _____
Last series of Chemotherapy? _____
List any other disorders requiring hospitalization or doctor's care? _____
_____
Do you receive chiropractic care? Yes/No If so, how often? _____
Do you receive massage therapy? Yes/No If so, how often? _____
Have you ever had a colonic irrigation? Yes/No If so, last series? _____Results? _____
Have you ever had a Barium Enema? Yes/No If so, what year? _____
Have you ever had a Colonoscopy? Yes/No If so, what year? _____
Have you ever had a Colon Surgery? Yes/No If so, what year? _____
Have you ever had a Rectal Surgery? Yes/No If so, what year? _____

Please circle if you suffer from any of the following:
Abdominal Hernia/ Aneurysm/ Arthritis/ Asthma/ Allergies/ Backache: Upper/ Lower/ Bad Breath/ Cardiac Disease/ Colitis/ Constipation/ Cirrhosis/ Candidiasis/ Chronic Fatigue/ Diabetes/ Diarrhea/ Severe Diverticulitis/ Fissures/ Fistulas (Colon)/ Foot aches/ Eyes/ Genitals/ Gastritis/ Heart/ Severe Hemorrhoids/ Headaches/ Indigestion/ Kidney/ Prostate/ Skin Disorders/ Uterus

Pulse rate: _____ Blood pressure: Low/Normal/High Cholesterol: Low/Normal/High

If female, are you pregnant? Yes/No If so, how many weeks? _____

What does your daily diet consist of? Circle that apply

Meals with protein and starches	Fish	Coffee/Tea
White flour products	Milk	Bottled Water
Fast Food/Restaurants	Cheese	Alcoholic drinks
Packaged Foods	Sugar Free/Fat Free Products	Antacids
Red Meat	Multi-Grain Products	Aspirin
Late Night Snacks	Fresh Fruits/Vegetables (Raw)	Vitamins
Soft Drinks	Canned Fruits/ Vegetables	Cigarettes

PLEASE CONTINUE ->

Bowel movements:

___One or more times per day	Size: _____	Do you need laxatives? Yes/No
___2-3 times per week	Color: _____	Odor? Yes/No
___Once per week	Shape: _____	Do you strain? Yes/No
___2-3 times per month		Have rectal bleeding? Yes/No

Do you use fiber? Yes/No If so, what kind? _____
Do you exercise? Yes/No If so, how often? _____
What are your health goals? _____
_____

In case of emergency, whom should we call? Phone: _____
Name: _____ Relationship: _____

I, the undersigned, hereby acknowledge that my therapist has not, is not and will not prescribe, (order for use as medicine) for me at any time and I, the undersigned, will not hold them accountable for such. The therapist is helping me with natural hygiene at my request and is not diagnosing not treating disease, nor practicing any form of medicine.

Signature_____ **Date:** _____

_____

OFFICE USE ONLY **Colonic Observations**

Scope:	Adult Child
Rectum:	Piles-Int. Piles-Ext Fissure
Anus:	Normal Pubic Coccyx
Bowel:	Atonic Spastic Ptosis
Waste:	Const. Diarrhea Chyme Normal
Mucus:	Normal New Toxic
Cecum:	Normal Heavy Toxic
Water:	5-Gal 10-Gal 15-Gal 20-Gal
Perist.:	Normal Hyper Hypo
Gas:	Putrefaction Fermentation

Notes

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