Colon Hydrotherapy Health Questionnaire

Date _____

Name _____ Birthday _____

Address _____

City _____ State _____ Zip _____

Home _____ Cell _____ Work _____

Email _____

Refered By _____

Are you currently under a Medical Doctor's care? Yes No

Please Explain: _____

Are you Pregnant? Yes No If yes how many weeks are you? _____

Please put an "X" beside anything that is currently a health challenge.

____ Constipation	____ Fatigue/Lack of Energy	____ Swollen Glands
____ Diarrhea	____ Allergies	____ Gall Bladder/Gall Stones
____ Hemorrhoids	____ Arthritis	____ Cysts/Fibroids/Tumors
____ Indigestion	____ Hernia	____ Fungus/Yeast Inf/ Candida/Parasites
____ Acid Reflux	____ Diabetes/Hypoglycemia	____ Prostate Problems
____ Belching/Flatulence/Gas	____ Sinus Problems	____ Headaches/Migraines
____ Ulcers	____ Hepatitis/Liver Problems	____ High/Low Blood Pressure
____ Colitis	____ Herpes/Other STDs	____ Memory Problems
____ Diverticulitis/Diverticulosis	____ Acne/Psoriasis/Eczema	____ Menstrual Problems
____ Fissures/Fistulas	____ Parkinson's Disease	____ Psyche Disorders (depression, etc)
____ Crohns Disease	____ Cancer	____ Water Retention
____ Back Aches/Herniated Disks	____ Stroke	____ Body Odor/Foot Odor/Bad Breath

Please list all other conditions not listed above: _____

_____

How often do you have a bowel movement? _____

Do you have hemorrhoids or other rectal problems? _____

How often do you use the following (include herbal)?

Stool Softener? _____ Suppositories? _____ Enemas? _____ Laxative? _____

Have you ever had rectal bleeding? Yes No If "Yes" when? _____

Is there any family history of digestive problems, cancer or heart disease? Yes No

What do you hope to achieve at this appointment? _____

Consent for Treatment

I hereby request and consent to the performance of Colon Hydrotherapy treatments on me (or on the patient named below, for whom I am legally responsible) by a licensed Colon Hydrotherapist who now, or in the future, treat me while employed by, working or associated with or serving as back-up for Gardens Wellness Center.

By signing below, I show that I understand the above consent to treatment, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Signature _____ Date _____

Legal Guardian Signature _____ Date _____

Legal Guardian Printed Name _____

You will be charged for appointments cancelled less than 24 hours in advance.