Inner Harmony Colon Hydrotherapy Health Questionnaire

Name: _____M/F___ Date: _____
Address: _____City_____ST_____Zip_____
Phone Numbers: H: _____ C: _____ Email: _____
Height: _____ Weight: _____ Birthdate: _____
Are you currently under a doctor's care? _____
If so, please explain: _____
Doctor's Name: _____ Doctor's Telephone Number: _____
Are you pregnant? _____ Childbirth History: _____
Please list all known allergies: _____
Please list all surgeries: _____
Please list all medications/supplements: _____
Do you exercise and, if so, what type and how often? _____
Do you have any family history of digestive problems? _____
How did you hear about Inner Harmony CHT?
_____

Please put a "√" beside any current health challenge and a "**P**" beside any past health challenge:

___ Acid Reflux
___ Allergies
___ Anemia
___ Antibiotic Use
___ Arthritis
___ Asthma
___ Backaches
___ Belching
___ Birth Control Pills
___ Blood Pressure Problems
___ Breast Implants
___ Cancer
___ Colitis
___ Constipation
___ Cysts/Tumors
___ Depression
___ Diabetes
___ Diarrhea
___ Difficult Menstruation
___ Dizziness
___ Fatigue
___ Flatulence / Gas
___ Gallbladder Problems
___ Headaches
___ Hemorrhoids
___ Hepatitis
___ Herpes
___ Hiatal Hernia
___ Hypoglycemia
___ High/Low Blood Pressure
___ Impaired Hearing
___ Indigestion
___ Infections
___ Insomnia
___ Irritability
___ Parasites
___ Parkinson's
___ Pregnancies
___ Prostate Problems
___ Sinus Problems
___ Swollen Glands
___ Ulcers
___ Urination Problems
___ Vision Problems
___ Water Retention
___ Yeast Infections

Bowel Habits

How often do you normally have a bowel movement? _____
Are they spontaneous? _____ Only after eating? _____ Requires straining? _____
Do you have hemorrhoids or any other rectal problems? _____
Do you use laxatives? _____ Stool softeners? _____ How often? _____

Diet

Please put a "**Y**" for yes and an "**N**" for no below. If "**Y**", please list amount and/or frequency.

___ Alcohol _____ ___ Tobacco _____
___ Coffee / Tea / Soda _____ ___ Water _____
___ Dairy Products _____

What is a typical breakfast? _____
What is a typical lunch? _____
What is a typical dinner? _____

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What do you hope to achieve from this appointment? _____

Please check whether you have or have had any of the following:

___Severe Cardiac Disease
___Aneurysm
___Severe Anemia
___GI hemorrhage/perforation
___Severe Hemorrhoids
___Severe diverticulitis
___Ulcerative Colitis
___Chrohns Disease
___Cirrhosis
___1st trimester of pregnancy
___Advanced pregnancy
___Renal Insufficiency
___Fissures/Fistulas
___Chemotherapy/Radiation Treatment
___Cancer
___Aids
___Recent Colon Surgery

If you answered yes to any please explain

_____

Are you currently taking any of the following medications Coumadin, Heparin, Plavix (blood thinners)?____

24 hour cancellation policy: If you must cancel your appoint please call at least 12 hours in advance or a $35.00 charge will be added to your bill. If there is no answer when you call, please leave a message.

Please initial_____

Please be advised that a $20.00 service will be added to your balance for any returned checks.

Please initial_____

Signature_____ Date_____