

Health(20)

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Occupation: _____ Email: _____

Age: _____ Birth Date: _____ Identified Gender: _____ Cis/Trans? _____

Height: _____ Weight: _____ Doctor's name: _____ Found us / Referred by: _____

Reason for colon hydrotherapy: _____

Have you received colon hydrotherapy before? _____ When? _____ How often? _____

How often do you have a bowel movement? _____ times per day _____ times per week

Do you have a family history of intestinal problems? Yes / No Specify _____

Have you undergone any internal surgeries? Yes / No Specify / when _____

Have you had a barium x-ray? _____ Colonoscopy? _____ Dates _____ Reason / Results _____

Have you ever been treated for colon problems? _____ Why and when? _____

Do you currently use any of the following? How often? (daily, number of times per week/month)

Laxatives _____ Stool Softener _____ Psyllium _____ Bentonite _____ Enemas _____

My bowel movements are: Regular _____ Spontaneous _____ Occur only after eating _____ Effortless _____

Require Straining _____ Painful _____ Incomplete _____ Contain blood _____ Mucous _____

Over the counter or prescription medications used in the last 6 months:

Check all that apply now or in the past: Toxic chemical exposure _____ Substance abuse _____ Eating disorders _____

Water intake per day _____ Fasting? (frequency) _____ Describe your diet: _____

Are you currently undergoing any other therapies? _____ Specify: _____

Please check and/or give approximate dates for all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Current/Possible Pregnancy
(Must be at least 6 weeks post-partum) | <input type="checkbox"/> Stroke
(or history of carotid artery disease) |
| <input type="checkbox"/> Cancer of the colon or GI tract | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Recent history of GI bleeding | <input type="checkbox"/> Seizures, epilepsy or psychosis |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Uncontrolled hypertension |
| <input type="checkbox"/> Carcinoma of the rectum or colon | <input type="checkbox"/> Abdominal surgery (type?, less than 6 months ago?) |
| <input type="checkbox"/> Intestinal perforation | <input type="checkbox"/> Abdominal hernia (unrepaired) |
| <input type="checkbox"/> Colon or rectal surgery | <input type="checkbox"/> Acute abdominal pain |
| <input type="checkbox"/> Vascular aneurysm | <input type="checkbox"/> Diverticulitis / diverticulosis (circle) (symptom free 6 mos.) |
| <input type="checkbox"/> Renal insufficiency | <input type="checkbox"/> Crohn's disease / Ulcerative colitis (dr's signature needed) |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Anal fissures or fistula (acute anal tear? infected?) |
| <input type="checkbox"/> Severe anemia | <input type="checkbox"/> Severe hemorrhoids (currently active or bleeding?) |

Other symptoms, medical issues, diagnoses, or health concerns: _____

Colon hydrotherapy is not a recognized medical procedure in California. Colon hydrotherapy, the experience shared by the hydrotherapist, and any information provided or statements made by Health2o, its employees and/or representatives are personal opinion, and in no way meant to replace or imitate the care of a licensed health professional, to be taken as medical fact or used to diagnose or treat disease, but as suggestions, opinions and a sharing of ideas of alternative ways of

healthful living between the therapist and the client. We strongly advise anyone embarking on colon hydrotherapy to first seek the advice of their healthcare provider.

I have read and understand the disclaimer, and have filled out the questionnaire to the best of my knowledge.

Signature _____ Date _____