Health Intake Form

Save time at your first appointment by printing out this form and completing it ahead of time.

Name ____________________ Email ____________________

Address ____________________

Birth Date __________ Marital Status __________ Occupation __________

Home Phone __________ Work Phone __________ Cell Phone __________

Circle: Male Female Height ______ Weight ______

Current Medications ____________________

____

____

Current Supplements ____________________

____

____

Current Health Challenge or Goals ____________________

____

____

Stress Level (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Known allergies ____________________

Known injuries ____________________

Have you been hospitalized in the past year? Yes No

If yes, please give details ____________________

____

____

Do you currently have any contagious diseases? Yes No

If yes, please list ____________________

Have you had any surgeries? Yes No

If yes, please gives details and dates ____________________

____

____

Your Physician's Name ____________________

Address ____________________

Phone ____________________

Symptoms you are currently experiencing:

GENERAL
- ____ Headaches
- ____ Insomnia (inability to sleep)
- ____ Loss of weight
- ____ Dizziness
- ____ Fainting spells
- ____ History of seizures
- ____ Fatigue
- ____ Depression
- ____ Enlarged thyroid
- ____ Double/blurred vision
- ____ Other ______________________

CARDIOVASCULAR
- ____ High blood pressure
- ____ Hardening of the arteries
- ____ Angina (chest pain)
- ____ Poor circulation
- ____ Rapid heart rate
- ____ Irregular heart beat
- ____ Congestive heart failure
- ____ Swelling of ankles

MUSCLE AND JOINT
- ____ Arthritis
- ____ Bursitis
- ____ Low back pain
- ____ Neck pain
- ____ Swollen joints
- ____ Other pain __________________

GENTRO - URINARY
- ____ Kidney infection or stones
- ____ Painful urination
- ____ Prostate trouble
- ____ Kidney failure

RESPIRATORY
- ____ Shortness of breath
- ____ Chronic cough
- ____ Emphysema
- ____ Bronchitis
- ____ Asthma

GASTRO
- ____ Colitis
- ____ Constipation
- ____ Crohn's Disease
- ____ Ulcerative Colitis
- ____ Diverticulitis
- ____ Gall Bladder Disease
- ____ Hemorrhoids
- ____ Fissures/Fistulas
- ____ Liver trouble
- ____ Cirrhosis
- ____ Rectal bleeding
- ____ Vomiting of blood
- ____ Cancer
- ____ Family history of colon cancer

SKIN
- ____ Bruise easily
- ____ Dryness
- ____ Itching
- ____ Rash

WOMEN ONLY
- ____ Painful menstruation
- ____ Vaginal discharge
- ____ Breast pain

Last menstrual period ________________

Are you pregnant? Yes No

MASSAGE THERAPY GENERAL QUESTIONNAIRE

Have you had a massage previously? Yes No If yes, where and how often? ______________________________

Why have you chosen to get a massage?

____ Release stress or tension ____ Relieve muscle pain ____ Reduce appearance of cellulite

____ Referral ______________________________

HYDRO-COLON THERAPY QUESTIONNAIRE

Have you had a hydro-colon therapy previously? Yes No If yes, where and how often? ______________________

Do you use any of the following: ____ Laxatives ____ Enemas ____ Antacids

Why have you chosen Hydro-Colon Therapy?

____ Constipation ____ Bloating ____ Gas Pain ____ Diarrhea ____ Colitis ____ Cleansing ____ Illness

____ Referral ______________________________

How often do you have bowel movements ______________________ When was your last BM ________________

AGREEMENT (Please read and sign):

The practitioner giving me a Hydro-Colon Therapy treatment does not provide medical services of any kind. Clients are expected to seek and use such medical services as may be require from a physician. The service of Hydro-Colon Therapy is not designed to diagnose, treat or cure any disease or medical condition. Any medications or other supplementation prescribed by your physician should be continued. I agree that I have read and understand the above statement. All the information given by me, the client, here is true.

CLIENT SIGNATURE ____ DATE ________________