Zen Retreat Spa

Colon Hydrotherapy Questionnaire

Notice: Please understand answering these questions below we do not diagnose or prescribe; however, we do offer nutritional information only to help you with your mutual problem this procedure is for building better health.

Name ____ Age______ Occupation__________________________

Address_________________________________ City ______________________ State _________ Zip code __________________

Telephone (circle preferred contact) Home __________________ Work____________________ Cell______________________

Email: ____ Referred By: _________________________

Height_____________________ Weight____________________ Birth date____

Are you currently under a medical doctor's care? ______________ if yes please explain____________________________________

____

Doctor's name____ Telephone____

Are you pregnant? _______ List all known allergies____

List all surgeries ____

List all medications (including over the counter): ____
_

Have you ever had a Colonic? _____ Yes ______ No If Yes When____

where____

Please put an "X" beside anything that is currently a health challenge. Put a "P" beside a past problem

____ Constipation
____ allergies
_____ swollen glands
____ Diarrhea
____ parasites
____ gall bladder
____ Hemorrhoids
____ yeast infections
_____ impaired hearing
_____ Indigestion
_____ insomnia
____ cysts/tumors
_____ belching
_____ anemia
_____ infections

_____ flatulence/gas
_____ irritability
____ antibiotic use
_____ Ulcers
____ hypoglycemia
____birth control pills
_____ Colitis
____ diabetes
____prostate problems
_____ Arthritis
____ sinus problems
____urination problem
_____ Headaches
_____ hepatitis
____blood pressure

_____ Fatigue
_____ herpes
_____breast implants
_____ back ache
_____ asthma
_____ pregnancies
_____ Vision problems
_____ Parkinson's
_____ psyche disorders
_____ Dizziness
_____ cancer
_____water retention
_____ Acid reflux
_____ hiatus hernia
_____difficult menstruation

How often do you have a bowel movement? Per Day? ____

(Circle) Are they spontaneous? Only after eating requires straining Effortless

Do you have hemorrhoids or other rectal problems? ______if yes please explain ____

Do you use a laxative? ___ Herbal laxative ____ Stool softener ____ Suppositories ___ Enemas _____ other

Have you ever had rectal bleeding? ______ If yes, when? ____

List all supplements: ____

Mark “Y” for yes and “N” for no. If yes, list amount and frequency.

___ Coffee ___ Tea ___ Soda ___ Alcohol ________diet programs____

___ vegetarian/vegan ___ exercise (type and frequency) ___________-hour’s sleeping__________ Tobacco ______________

Stress management (type) ______________________ ___ sugar/salt cravings_______________________________________

_________ Water intake per day __________ Dairy products ____________________ How many mercury fillings do you have in your teeth?

____

What do you hope to achieve from this appointment? ____

We reserve the right to restrict to or decline acceptance of a client. This is certifying that I am requesting services on my own imitative, and I realize that the therapist and Zen Retreat Spa Inc. do not diagnose ailments. I hereby agree that the answers I have given are true to the best of my knowledge and will not hold the therapist and/or Zen Retreat Spa Inc. liable in anyway.

Signature____ Date___________________________________

Progress Notes

Date _________ Therapist ______ Notes ____

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Date _________ Therapist ________ Notes ____

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Date _________ Therapist_________ Notes ____

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Date _________ Therapist ________ Notes ____

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Date ________ Therapist ________ Notes ____

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Date ________ Therapist __________ Notes ____

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Date ________ Therapist __________ Notes ____

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