

CLIENT QUESTIONNAIRE

Name_____ Date_____

Address, City, Zip_____

E-mail_____

Phone_____ DOB_____

Occupation_____ Hgt/Wgt_____

Marital Status_____ Emergency person/number_____

How did you hear of Integrated Body Health _____

y complaint:_____

This information will help us
meet your individual needs.
Thank you for taking time to fill
it out.

Primary Care Physician_____ Chiropractor_____ Other_____

IT IS IMPORTANT to have a thorough understanding of your physical condition to provide you with a quality health care program. Take your time and **check** any of the following you have had. UNDERLINE if **currently** have.

GASTROINTESTINAL

__recent constipation

__chronic constipation

__diarrhea

__intestinal worms

__colitis

__diverticulitis

__recurrent abdominal pain

__hemorrhoids

__bad breath

__bloody/black stools

__fistula or fissures

__ulcers

__abdominal hernia

__Crohn's Disease

__IBS

__gas, belching

__tender stomach

__flatulence

METABOLIC

__underweight

__overweight

__diabetes

__low blood sugar

__high cholesterol

__frequent heartburn

__obesity

MUSCULOSKELETAL

__recent accident

__painful joints

__leg or muscle cramps

__muscle pain

CONTAGIOUS DISEASE

__HIV

__Epstein Barr Virus

__Mononucleosis

__Hepatitis

__Herpes

GENERAL

__severe heart disease

__kidney disease

__cirrhosis

__cancer

__pregnant

__aneurysm

__high/low blood pressure

__frequent headaches

__nervousness, anxiety

__insomnia

__irritability

__anemia

__arthritis

__menstrual problems

__prostate trouble

__fatigue

__skin disorders

__nursing mother

Are you on a nutritional diet program? _____ Yes _____ No

Notes

Please list the supplements you are taking:

1 _____ 2 _____

3 _____ 4 _____

5 _____ 6 _____

Have you had a: Barium enema _____ yes _____ no _____ year

Rectal surgery _____ yes _____ no _____ year

Colonoscopy _____ yes _____ no _____ year

1 Surgeries

Date

Rectal? _____ Abdominal? _____ Other? _____

2 Currently Taking - Prescription medications/Laxatives/Herbs/Over the Counter Medications

3 Allergies _____

4 Colon Hydrotherapy _____

5 Habits	How much?	How much?	How much?	How much?			
Water	_____	Coffee	_____	Alcohol	_____	Exercise	_____
Tobacco	_____	Tea	_____	Sodas	_____	Rest	_____

6 Bowel Movements:

Occurrence:

Use of laxatives:

____ Twice daily	____ Spontaneous	____ Frequent
____ Once a week	____ Painful	____ Occasional
____ About every ____ days	____ Effortless	____ Never
____ Daily	____ Often requires straining	What type _____

- I understand that treatments are given by a certified colon hydrotherapist
- Colon hydro-therapy is a process, not a quick cure. Multiple sessions with good eating and exercise are necessary to achieve optimum results. Please discuss this with your physician, as you see fit.
- I have listed all my known medical conditions and physical limitations and I will inform the therapist of any changes in my physical health.
- I agree to pay for all scheduled appointments that I am unable to keep unless I notify the therapist at least 24 hours in advance.

Signature: _____ Date: _____