CLIENT QUESTIONNAIRE

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

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 _____

Please describe your primary complaint:_____

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:_____