To Your Health Colon Hydrotherapy

Salud Natural Wellness Center Inc

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919-803-7137

PLEASE PRINT LEGIBLY All information for office use only.

Date_____ DOB_____ Age_____ Gender _____

Name_____ Phone _____

Full Address _____

Email (for newsletters and special offers) _____

Occupation_____ How did you hear about us? _____

Emergency contact info _____

Personal goals relating to services _____

Military (past or present) or immediate family member _____

Colonic clients: Is this your first colonic?___Y___N If not, when and where was the last one? _____

GENERAL HEALTH

Have you been hospitalized?_____When?_____Why? _____

Have you been diagnosed with a major illness/disease?_____When?_____What? _____

_____

_____

Please explain any kind of medical treatments you are currently receiving. _____

_____

Please list any medications you are taking and why. _____

_____

_____

Please list any supplements you are taking and why. _____

_____

_____

Please list any kind of 'program' you are on. Ex: fasting, weight loss, nutrition, etc. _____

_____

_____

_____

Please list all allergies. _____

Are you currently pregnant? □ yes □ no How many pregnancies?____full term___miscarriage___abortion___.

Did you gain additional weight with each pregnancy? □ yes □ no

Did you lose your pregnancy weight with each child? □ yes □ no

How often are your bowel movements?_____Constipation? □ yes □ no

Do you have any metal surgical parts in your body? □ yes □ no Do you currently have, or have you had in the past, any of the following: **C** for Current, **P** for Past

____ Abdominal gas/**pain**
____ **Abdominal hernia**
____ Acid reflux
____ AIDS/HIV
____ Anal bleeding
____ Anal discomfort/itching
____ Anxiety
____ Anemia
____ **Aneurysm**
____ Anorexia
____ Appendicitis
____ Arthritis
____ Asthma
____ Atonic colon
____ Autoimmune disorder
____ Bad breath
____ Belching
____ Bloating, general
____ Bloating, after eating
____ Blood pressure high/low
____ Blood sugar high/low
____ Bulimia
____ **Cancer**: type _____
____ Candida
____ Celiac disease
____ Cholesterol high/low
____ Chronic fatigue
____ Chronic pain
____ **Cirrhosis**
____ **Colitis**
____ **Congestive heart failure**
____ **Contagious disease**
____ Constipation
____ Cramping
____ **Crohn's disease**
____ Depression
____ Diabetes
____ Dialysis
____ Diarrhea
____ Diverticulosis
____ **Diverticulitis**
____ Dizziness
____ Eczema
____ Edema
____ Environmental allergies
____ **Epilepsy**
____ Epstein-Bar Virus
____ Extreme weight gain/loss
____ Fainting
____ Fatigue after eating
____ Fever/chills
____ Fibromyalgia
____ Fibroid cysts
____ **Fissure/fistula**
____ Gallstones
____ Headaches/migraines
____ **Heart condition**
____ **Hemorrhoids**
____ IBS
____ Indigestion
____ **Intestinal perforation**
____ Irregular period
____ Kidney disorder
____ Kidney stones
____ Liver disorder
____ Loss of sleep
____ Low libido
____ Lung disorder
____ Lupus
____ Lyme disease
____ Metal toxicity
____ Menopause
____ Mental disorder
____ Nausea
____ Osteopenia
____ Osteoporosis
____ Pace maker
____ Parasites
____ PMS
____ Polyp
____ Prolapsed colon
____ Prostate disorder
____ **Recent surgery**
____ **Rectal bleeding**
____ **Renal insufficiencies**
____ **Seizures**
____ Sinus condition
____ Skin condition
____ Spastic colon
____ Sweats
____ Thyroid disorder
____ Ulcer
____ Urinary tract infection
____ Vomiting
____ Other:

DIETARY

Are you: Vegan?_____Vegetarian?_____Omnivorous?(eat animal protein) _____

Do you want to change?_____To which group?_____Why?_____

Usual breakfast _____

Usual lunch _____

Usual dinner _____

Usual snack _____

List any cravings you have on a regular basis _____

Do you have sensitivities to any of the following?_____Lactose _____casein_____wheat_____gluten

_____night shade foods_____ additives_____dyes_____MSG_____preservatives_____latex

Have you had any significant physical and/or emotional trauma?_____If yes, please explain. _____

_____

If you have an exercise routine, please explain. _____

Indicate your consumption accordingly.
H-Heavy(5-7 times per week) **M-Moderate**(2-4 times per week) **L-Light**(1 time or less per week) **N-**Never

____ fresh fruit
____ fresh vegetable juice
____ fresh fruit juice
____ smoothies
____ nuts/seeds
____ beans
____ meats:
chicken___ beef_____ pork_____ fish
lamb_____ shellfish_____ turkey _____
____ eggs
____ salad
____ raw vegetables
____ water
____ salt
____ organic foods

____ candy
____ alcohol
____ cooked vegetables
____ caffeine (coffee/tea)
____ soda
____ dairy: milk, cheese, yogurt, ice cream
____ nightshade family:
eggplant_____ peppers____
potatoes _____ tomatoes____
____ processed foods
____ flour products
____ fast foods
____ sugar
____ tobacco
____ antacids

OTHER:
How much water do you drink per day? What is the source? _____

Do you drive a Hybrid? □ yes □ no

Do you live near radio towers, high power lines, sub-station, etc.? □ yes □ no

What electrical appliances are in your bedroom?_____
Where is your cell phone while you sleep? _____

Ever have Lyme disease? □ yes □ no What was the treatment? _____

Ever been exposed to mold? □ yes □ no Explain. _____

Any amalgam fillings (silver filings)? □yes □ no How many? _____

Any root canals? □ yes □ no How many? _____

How many wisdom teeth have been removed? _____
Do you have implants of any kind? (Breast, cheek, etc.) _____

All information provided above is true and complete. I have no expectation of a diagnosis, prescription or cure and service/consultation is NOT a substitute for medical exam, treatment, or diagnosis.

I understand the required 48 hour cancellation notice for all reschedules and cancellations with the only exception being a medical emergency for myself or my immediate family. I agree to pay the $55 fee for missed appointments if I fail to provide the required notice.

Signature_____ Date _____