

# The Happy Colon Client Information

I, \_\_\_\_\_, understand it is my right to experience health assistance of my choice and I accept full responsibility of any outcome. Whether or not I ask for assistance is my decision. All decisions relative to my health must be made by me.

PLEASE COMPLETE AND BRING WITH YOU TO YOUR FIRST VISIT.

NAME: \_\_\_\_\_

PHONE: HOME \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

E-MAIL: \_\_\_\_\_ BLOOD TYPE: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ DO YOU HAVE ANY CHILDREN? \_\_\_\_\_ HOW MANY? \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ HOW DID YOU LEARN OF OUR SERVICES \_\_\_\_\_

DO YOU HAVE MERCURY FILLINGS OR OTHER DENTAL PROBLEMS? \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

\*\*\*\*A 24 HOUR CHANGE OF APPOINTMENT IS REQUIRED, OTHERWISE AN \$85 FEE WILL BE CHARGED. \*\*\*\*

HOW OFTEN DO YOU CONSUME THE FOLLOWING ITEMS?

DAIRY PRODUCTS (milk, ice cream, cheese, yogurt, etc.): DAILY \_\_\_ WEEKLY \_\_\_ MONTHLY \_\_\_ RARELY \_\_\_ NEVER \_\_\_

RED MEAT: DAILY \_\_\_ WEEKLY \_\_\_ MONTHLY \_\_\_ RARELY \_\_\_ NEVER \_\_\_

CHICKEN: DAILY \_\_\_ WEEKLY \_\_\_ MONTHLY \_\_\_ RARELY \_\_\_ NEVER \_\_\_

FISH: DAILY \_\_\_ WEEKLY \_\_\_ MONTHLY \_\_\_ RARELY \_\_\_ NEVER \_\_\_

REFINED FLOUR (pasta, bread, cookies, etc.): DAILY \_\_\_ WEEKLY \_\_\_ MONTHLY \_\_\_ RARELY \_\_\_ NEVER \_\_\_

SODA: DAILY \_\_\_ WEEKLY \_\_\_ MONTHLY \_\_\_ RARELY \_\_\_ NEVER \_\_\_

COFFEE OR TEA (please specify): \_\_\_\_\_ DAILY \_\_\_ WEEKLY \_\_\_ MONTHLY \_\_\_ RARELY \_\_\_ NEVER \_\_\_

VEGETABLES: DAILY \_\_\_ WEEKLY \_\_\_ MONTHLY \_\_\_ RARELY \_\_\_ NEVER \_\_\_

FRESH FRUITS: DAILY \_\_\_ WEEKLY \_\_\_ MONTHLY \_\_\_ RARELY \_\_\_ NEVER \_\_\_

WHOLE GRAINS: DAILY \_\_\_ WEEKLY \_\_\_ MONTHLY \_\_\_ RARELY \_\_\_ NEVER \_\_\_

HOW MANY 8 OZ. GLASSES OF WATER DO YOU DRINK PER DAY? \_\_\_\_\_

PLEASE DESCRIBE YOUR EXERCISE HABITS:

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From the following list, what do you believe might be causing your fatigue?

Airborne: \_\_\_\_\_ Food: \_\_\_\_\_ Poor sleep habits: \_\_\_\_\_ Thyroid: \_\_\_\_\_ Stress: \_\_\_\_\_

Allergies: (Please list known) \_\_\_\_\_

Describe your hormone activity (your period as teen/menopause difficulties):

Family history: Diabetes: \_\_\_\_\_ Heart disease: \_\_\_\_\_ Asthma: \_\_\_\_\_

Died from Gall bladder disease: \_\_\_\_\_ Kidney disease: \_\_\_\_\_  
 Arthritis: \_\_\_\_\_ Stomach disorders: \_\_\_\_\_ Cancer: \_\_\_\_\_  
 Type of cancer: \_\_\_\_\_  
 Other: \_\_\_\_\_

Children: \_\_\_\_\_ #of Pregnancies: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Abortion: \_\_\_\_\_  
 Complications: \_\_\_\_\_

Mother: Age: \_\_\_\_\_ Died from: \_\_\_\_\_  
 Grandmother: Age: \_\_\_\_\_ Died from: \_\_\_\_\_  
 Grandfather: Age: \_\_\_\_\_ Died from: \_\_\_\_\_  
 Father: Age: \_\_\_\_\_ Died from: \_\_\_\_\_  
 Grandmother: Age: \_\_\_\_\_ Died from: \_\_\_\_\_  
 Grandfather: Age: \_\_\_\_\_ Died from: \_\_\_\_\_

**PLEASE CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:**

- |  |   |
|--|---|
| <input type="checkbox"/> CANCER (WHERE/WHEN) _____ | <input type="checkbox"/> CROHN'S DISEASE/COLITIS/DIVERTICULITIS |
| <input type="checkbox"/> SEVERE CARDIAC DISEASE    | <input type="checkbox"/> ANEURYSM                               |
| <input type="checkbox"/> SEVERE ANEMIA             | <input type="checkbox"/> GI HEMORRHAGE/PERFORATION              |
| <input type="checkbox"/> SEVERE HEMORRHOIDS        | <input type="checkbox"/> CIRRHOSIS                              |
| <input type="checkbox"/> FISSURES/FISTUALS (COLON) | <input type="checkbox"/> ABDOMINAL HERNIA                       |
| <input type="checkbox"/> RECENT COLON SURGERY      | <input type="checkbox"/> RENAL (KIDNEY) INSUFFICIENCY           |
| <input type="checkbox"/> ABNORMAL DISTENTION       | <input type="checkbox"/> LUPUS                                  |

DO YOU EXPERIENCE YEAST INFECTIONS? \_\_\_\_\_ HOW OFTEN? \_\_\_\_\_

**WOMEN ONLY:**

ARE YOUR PERIODS REGULAR? \_\_\_\_\_ DO YOU EXPERIENCE PMS? \_\_\_\_\_ CRAMPING? \_\_\_\_\_

ARE YOU PREGNANT? \_\_\_\_\_ IF SO, WHAT TRIMESTER? \_\_\_\_\_

## HEALTH CHECK LIST:

<p><b>DIGESTIVE TRACT:</b>    <input type="checkbox"/> NAUSEA  <input type="checkbox"/> DIARRHEA  <input type="checkbox"/> CONSTIPATION  <input type="checkbox"/> BLOATING  <input type="checkbox"/> BELCHING  <input type="checkbox"/> EXCESSIVE GAS  <input type="checkbox"/> HEARTBURN</p> <p><b>EARS:</b>                <input type="checkbox"/> ITCHY EARS  <input type="checkbox"/> EAR ACHE  <input type="checkbox"/> EAR INFECTIONS  <input type="checkbox"/> EAR DRAINAGE  <input type="checkbox"/> RINGING IN EARS  <input type="checkbox"/> HEARING LOSS</p> <p><b>EMOTIONS:</b>        <input type="checkbox"/> MOOD SWINGS  <input type="checkbox"/> ANXIETY  <input type="checkbox"/> NERVOUSNESS  <input type="checkbox"/> ANGER/IRRITABILITY  <input type="checkbox"/> DEPRESSION</p> <p><b>ENERGY:</b>            <input type="checkbox"/> FATIGUE  <input type="checkbox"/> APATHY</p> <p><b>LETHARGY:</b>        <input type="checkbox"/> HYPERACTIVITY  <input type="checkbox"/> RESTLESSNESS</p> <p><b>EYES:</b>                <input type="checkbox"/> WATERY EYES  <input type="checkbox"/> ITCHY OR RED EYES  <input type="checkbox"/> BLURRED VISION  <input type="checkbox"/> TUNNEL VISION</p> <p><b>HEART:</b>              <input type="checkbox"/> IRREGULAR HEART BEAT  <input type="checkbox"/> RAPID HEART BEAT  <input type="checkbox"/> CHEST PAINS</p> <p><b>JOINT/MUSCLE:</b>    <input type="checkbox"/> JOINT PAIN  <input type="checkbox"/> ARTHRITIS  <input type="checkbox"/> MUSCLE PAIN  <input type="checkbox"/> VARICOSE VEINS  <input type="checkbox"/> DIZZINESS</p>	<p><b>HEAD:</b>                <input type="checkbox"/> HEADACHES  <input type="checkbox"/> DIZZINESS</p> <p><b>LUNGS:</b>             <input type="checkbox"/> CHEST CONGESTION  <input type="checkbox"/> ASTHMA  <input type="checkbox"/> SHORTNESS OF BREATH</p> <p><b>MIND:</b>              <input type="checkbox"/> POOR MEMORY  <input type="checkbox"/> CONFUSION  <input type="checkbox"/> LEARNING</p> <p><b>DISABILITIES:</b>    <input type="checkbox"/> STUTTERING  <input type="checkbox"/> POOR CONCENTRATION</p> <p><b>MOUTH/THROAT:</b> <input type="checkbox"/> CHRONIC  <input type="checkbox"/> SORE THROAT  <input type="checkbox"/> SWOLLEN GLANDS  <input type="checkbox"/> CANKERSORES  <input type="checkbox"/> SENSITIVE TEETH-NERVES</p> <p><b>NOSE:</b>              <input type="checkbox"/> STUFFY NOSE  <input type="checkbox"/> SINUS PROBLEMS  <input type="checkbox"/> HAY FEVER  <input type="checkbox"/> SNEEZING  <input type="checkbox"/> EXCESS MUCUS</p> <p><b>SKIN:</b>                <input type="checkbox"/> ACNE  <input type="checkbox"/> HIVES OR RASHES  <input type="checkbox"/> HAIR LOSS  <input type="checkbox"/> EXCESSIVE SWEATING</p> <p><b>WEIGHT:</b>            <input type="checkbox"/> BINGE EATING  <input type="checkbox"/> CRAVINGS  <input type="checkbox"/> EXCESSIVE WEIGHT  <input type="checkbox"/> COMPULSIVE EATING  <input type="checkbox"/> WATER RETENTION  <input type="checkbox"/> UNDER WEIGHT</p> <p><b>OTHER:</b>              <input type="checkbox"/> FREQUENT ILLNESS  <input type="checkbox"/> FREQUENT URINATION  <input type="checkbox"/> GENITAL ITCH  <input type="checkbox"/> DISCHARGE</p>
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# HOLISTIC QUESTIONNAIRE

(All Questions Must Be Answered)

NAME \_\_\_\_\_ MALE/FEMALE \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE (HOME) \_\_\_\_\_ (WORK) \_\_\_\_\_ (CELL) \_\_\_\_\_

E-MAIL \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_ EXP DATE \_\_\_\_\_

EVER HAD A COLONIC BEFORE? \_\_\_\_\_ WHEN? \_\_\_\_\_ OTHER FORMS OF DETOX.CLEANSE \_\_\_\_\_

ARE YOU UNDER A DOCTOR'S CARE? \_\_\_\_\_ IF SO, PLEASE EXPLAIN \_\_\_\_\_

DOCTOR'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

MAJOR PHYSICAL COMPLAINTS \_\_\_\_\_

IF YOU ARE A WOMAN, ARE YOU PREGNANT? \_\_\_\_\_ IF SO, WHAT TRIMESTER? \_\_\_\_\_

LIST ANY SURGERIES YOU HAVE HAD \_\_\_\_\_

LIST ALL MEDICATIONS & SUPPLEMENTS YOU NOW TAKE REGULARLY (INCLUDING OVER-THE-COUNTER) \_\_\_\_\_

LIST ALL KNOWN ALLERGIES \_\_\_\_\_

HOW MANY BOWEL MOVEMENTS PER DAY DO YOU USUALLY HAVE? \_\_\_\_\_

DO YOU HAVE TO STRAIN TO HAVE A BOWEL MOVEMENT? \_\_\_\_\_

DO YOU USE A STOOL SOFTENER OR LAXATIVE? \_\_\_\_\_ HERBAL LAXATIVE? \_\_\_\_\_

SUPPOSITORY? \_\_\_\_\_ DO YOU HAVE HEMMORIODS OR OTHER RECTAL PROBLEMS? \_\_\_\_\_

HAVE YOU HAD ANY RECTAL BLEEDING? \_\_\_\_\_ IF SO, WHEN? \_\_\_\_\_

HAVE YOU EVER BLED FROM OTHER BODILY ORIFICES? \_\_\_\_\_ IF SO, EXPLAIN \_\_\_\_\_

HAVE YOU EVER HAD:

BARIUM ENEMA \_\_\_\_\_ YEAR \_\_\_\_\_ COLONOSCOPY \_\_\_\_\_ YEAR \_\_\_\_\_

COLON SURGERY \_\_\_\_\_ YEAR \_\_\_\_\_ RECTAL SURGERY \_\_\_\_\_ YEAR \_\_\_\_\_

WHAT WOULD YOU LIKE TO RECEIVE FROM THIS APPOINTMENT? IF THERE IS THERE ANYTHING SPECIFIC YOU WOULD LIKE TO WORK ON DURING THE SESSION, WHAT IS YOUR GOAL?

## CANCELLATION POLICY:

We understand that circumstances can and do occasionally arise which would make you unable to attend a scheduled appointment. To prevent any late cancellation charges, our policy requires that you give us 24 hours notice of any cancellation, at which time, we would be happy to reschedule your appointment. If less than 24 hours is given, you may be required to pay the full amount of the missed appointment. We feel this is the fairest policy for all concerned, and appreciate your cooperation in this matter.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable. I hereby approve that the colon hydrotherapist can touch me in conjunction with the procedure. I also agree that I am responsible for all bills incurred at this office. The colon hydrotherapist will not be held responsible for any preexisting medically diagnosed conditions, and I understand that they do not diagnose or prescribe themselves.

IF YOU ARE A FEDERAL, STATE, OR LOCAL AGENT, UPON ENTERING THESE PREMISES, YOU MUST DECLARE SAME OR UNDER THE BIVENS ACT - ARTICLE 42 BE HELD PERSONALLY AND INDIVIDUALLY LIABLE.

Signature \_\_\_\_\_

Please continue on other side

CHECK [/] FOR PRESENT CONDITIONS

MARK [X] FOR PAST CONDITIONS

INTELLECTUAL CENTER

WORLD CENTER

GROUNDING CENTER

- DOUBLE/BLURRED VISION
- FALLING HAIR EXCESSIVE
- EAT WHEN NERVOUS
- BITTER, METALLIC TASTE
- IN MOUTH IN MORNING
- DRY MOUTH, EYES, NOSE
- EYELIDS SWOLLEN, PUFFY
- EYES OR NOSE WATERY
- DIFFICULTY REMEMBERING
- SNEEZING ATTACKS
- MOODS OF DEPRESSION
- WORRIED, FEEL INSECURE
- IRRITABLE BEFORE MEALS
- FAINTNESS WHEN MEALS
- ARE DELAYED
- COATED TONGUE
- CAN'T GET THOUGHT OUT
- OF HEAD
- FREQUENT NOSEBLEEDS
- NIGHTMARE-TYPE BAD
- DREAMS
- NOISES IN HEAD OR EARS
- KEYED UP
- SUSCEPTIBLE TO COLDS
- AFTERNOON HEADACHES
- GET DROWSY OFTEN
- CAN'T GET TO SLEEP
- BAD BREATH (HALITOSIS)
- CRAVE CANDY OR COFFEE
- FEVER EASILY RAISED

- OVEREATING SWEETS UPSET
- HISTORY OF GALLSTONES
- ACID FOODS UPSET
- INDIGESTION 1/2 TO 1 HOUR
- AFTER MEALS OR 3-4 HRS LATER
- WAKEN AFTER FEW HOURS SLEEP;
- HARD TO GET BECK TO SLEEP
- HOARSENESS FREQUENT
- BREATHING IRREGULAR
- DIFFICULTY SWALLOWING
- MILK PRODUCTS DISTRESS
- DULL PAIN IN CHEST & LEFT ARM
- STOMACH "BLOATING" AFTER
- MEALS
- SOUR STOMACH FREQUENT
- CIRCULATION POOR
- TENSION UNDER RIB CAGE
- PULSE SPEEDS AFTER MEAL
- DIGESTION DIFFICULT
- "BUTTERFLY" STOMACH, CRAMPS
- AWARE OF BREATHING HEAVILY
- BILIOUSNESS
- HEART PALPITATES IF MEALS
- OR DELAYS
- CONSTIPATION/DIARRHEA ALTERNATING
- MUCOUS COLITIS
- SUSCEPTIBLE TO ASTHMA, BRONCHITIS
- "NERVOUS" STOMACH

- BURNING FEET
- ITCHING SKIN AND FEET
- BOWEL MOVEMENTS
- PAINFUL AND DIFFICULT
- LOSS OF LEG ENERGY
- MUSCLE/TOE/LEG CRAMP
- SWOLLEN ANKLES
- LOWER BOWEL GAS A FEW
- HOURS AFTER EATING
- SKIN PEELS ON FEET
- STOOLS ALTERNATE SOFT/
- WATERY
- URINE AMOUNT REDUCED
- MUSCLE CRAMPS, WORSE
- DURING, GET "CHARLEY
- HORSE"
- FREQUENT URINATION
- STOOL HAS FOUL ODOR
- BURNING OR ITCHING
- ANUS
- BLOOD IN STOOL
- RECTAL OR ANAL
- BLEEDING

WORLD CENTER

- SIGH FREQUENTLY, "AIR
- HUNGRY"
- PERSPIRE EASILY
- PRESSURE IN PIT OF STOMACH
- EXTREMITIES COLD, CLAMMY
- HEART POUNDS AFTER
- RETIRING
  
- HANDS & FEET FALL ASLEEP EASILY, NUMBNESS
- PAIN BETWEEN SHOULDER BLADES
- HISTORY OF GALL BLADDER PROBLEMS

- STOOLS IN LIGHT COLOR
- SENSITIVE TO HOT WEATHER
- LOSE TASTE FOR MEALS
- EXCESSIVE APPETITE
- GET "SHAKY" IF HUNGRY
- VOMITING FREQUENTLY
- PULSE SLOW, IRREGULAR
- GAG EASILY
- SHORTNESS OF BREATH
- GAS SHORTLY AFTER EATING
- APPETITE REDUCED
- NEURALGIA-LIKE PAIN

MISCELLANEOUS

- DRY SKIN
- DIZZINESS
- FATIGUE, RELIEVED BY EATING
- HUNGRY BETWEEN MEALS
- NEED TO OPEN WINDOWS IN
- CLOSED ROOMS
- LAXATIVES USED OFTEN
- SKIN RASHES FREQUENT
- COLD SWEATS OFTEN
- BRUISE EASILY; "BLACK &
- BLUE" SPOTS
- BURNING STOMACH
- SENSATIONS
- JOINTS STIFF AFTER ARISING
- STRONG LIGHT IRRITATES

**PLEASE READ BEFORE SIGNING:** I HAVE HONESTLY ANSWERED ALL ABOVE QUESTIONS AND AM NOT INTENTIONALLY WITHHOLDING INFORMATION ABOUT MY HEALTH.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_