



Health Intake Form

Save time at your first appointment by printing out this form and completing it ahead of time.

Name _____ Email _____

Address _____

Birth Date _____ Marital Status _____ Occupation _____

Home Phone _____ Work Phone _____ Cell Phone _____

Circle: Male Female Height _____ Weight _____

Current Medications _____

Current Supplements _____

Current Health Challenge or Goals _____

Stress Level (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Known allergies _____

Known injuries _____

Have you been hospitalized in the past year? Yes No

If yes, please give details _____

Do you currently have any contagious diseases? Yes No

If yes, please list _____

Have you had any surgeries? Yes No

If yes, please give details and dates _____

Your Physician's Name _____

Address _____

Phone _____

Symptoms you are currently experiencing:

GENERAL

- Headaches
- Insomnia (inability to sleep)
- Loss of weight
- Dizziness
- Fainting spells
- History of seizures
- Fatigue
- Depression
- Enlarged thyroid
- Double/blurred vision
- Other _____

CARDIOVASCULAR

- High blood pressure
- Hardening of the arteries
- Angina (chest pain)
- Poor circulation
- Rapid heart rate
- Irregular heart beat
- Congestive heart failure
- Swelling of ankles

WOMEN ONLY

- Painful menstruation Last menstrual period _____
- Vaginal discharge Are you pregnant? Yes No
- Breast pain

MUSCLE AND JOINT

- Arthritis
- Bursitis
- Low back pain
- Neck pain
- Swollen joints
- Other pain _____

GENTRO - URINARY

- Kidney infection or stones
- Painful urination
- Prostate trouble
- Kidney failure

RESPIRATORY

- Shortness of breath
- Chronic cough
- Emphysema
- Bronchitis
- Asthma

GASTRO

- Colitis
- Constipation
- Crohn's Disease
- Ulcerative Colitis
- Diverticulitis
- Gall Bladder Disease
- Hemorrhoids
- Fissures/Fistulas
- Liver trouble
- Cirrhosis
- Rectal bleeding
- Vomiting of blood
- Cancer
- Family history of colon cancer

SKIN

- Bruise easily
- Dryness
- Itching
- Rash

MESSAGE THERAPY GENERAL QUESTIONNAIRE

Have you had a massage previously? Yes No If yes, where and how often? _____

Why have you chosen to get a massage?

- Release stress or tension Relieve muscle pain Reduce appearance of cellulite
- Referral _____

HYDRO-COLON THERAPY QUESTIONNAIRE

Have you had a massage previously? Yes No If yes, where and how often? _____

Do you use any of the following: Laxatives Enemas Antacids

Why have you chosen Hydro-Colon Therapy?

- Constipation Bloating Gas Pain Diarrhea Colitis Cleansing Illness
- Referral _____

How often do you have bowel movements _____ When was your last BM _____

AGREEMENT (Please read and sign):

The practitioner giving me a Hydro-Colon Therapy treatment does not provide medical services of any kind. Clients are expected to seek and use such medical services as may be require from a physician. The service of Hydro-Colon Therapy is not designed to diagnose, treat or cure any disease or medical condition. Any medications or other supplementation prescribed by your physician should be continued. I agree that I have read and understand the above statement. All the information given by me, the client, here is true.

CLIENT SIGNATURE _____ DATE _____