

Inner Garden Colon Hydrotherapy Client Information Questionnaire

Please complete the following questions and email to: Innergarden@shaw.ca or fax to: 780-665-6202
All information is kept confidential.

Personal Data (please print)

First Name:

Last Name:

Address:

City:

Postal Code:

Telephone: Home:

Work:

Cell:

E-Mail:

Occupation:

Date of Birth:

Gender:

How did you find out about us?

__ Practitioner (*name & specialty*) _____

__ Physician (*name & specialty*) _____

__ Friend (*friend's name*) _____

__ Internet / website search

__ Other (*Please specify*) _____

Colon Health:

Is this your first Colon Hydrotherapy session? _____ Yes _____ No

If not, where and when was your most recent visit?

What, if any, is your prior experience with colon cleansing, other than hydrotherapy?

___ fasting ___ juicing ___ herbs ___ Health spa ___ other _____

Are you currently fasting? ___ Yes ___ No Are you currently cleansing? ___ Yes ___ No

If yes, type of fast or cleanse program _____

My intention for hydrotherapy is _____

Which of the following apply to you? Use "**C**" for **C**urrently, "**P**" for **P**ast.

- | | | |
|-----------------------------|---------------------------|---------------------------------|
| ___ Abdominal Gas | ___ Crohn's | ___ Irritable Bowel Syndrome |
| ___ Anal discomfort/itching | ___ Diverticulitis / osis | ___ Lactose intolerance |
| ___ Anal / rectal bleeding | ___ Diarrhea | ___ Nausea |
| ___ Appendicitis | ___ Fatigue after eating | ___ Parasites |
| ___ Atonic colon | ___ Fissure | ___ Polyps |
| ___ Bad breath | ___ Fistula | ___ Poor appetite |
| ___ Belching / bloating | ___ Gallstones | ___ Rectal / GI hemorrhaging |
| ___ Carcinoma | ___ Gastroparesis | ___ Redundant / prolapsed colon |
| ___ Celiac disease | ___ Hemorrhoids | ___ Reflex / heartburn |
| ___ Colitis | ___ Hernia | ___ Spastic colon |
| ___ Constipation | ___ Hungry all the time | ___ Vomiting |
| ___ Cramping | ___ Indigestion | ___ Worms in stool |

Please list any intestinal-related procedures you have had, along with the year it took place:

___ barium enema ___ colonoscopy ___ sigmoidoscopy ___ surgery ___ other _____

Bowel Health:

How many bowel movements do you usually have?

Per day _____ # Per week _____

Do you strain to have a movement? Yes ___ No ___

Does the movement feel complete? Yes ___ No ___

Please check applicable responses. The stool . . .

- ___ Shows signs of mucus
___ Shows signs of blood
___ Has a strong odor

General Health:

Have you been hospitalized within the past year? _____ In the past 5 years? _____

If yes, why? _____

Which of the following apply to you? Use "C" for **C**urrently, "P" for **P**ast.

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Edema | <input type="checkbox"/> Lyme disease |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Environmental sensitivities | <input type="checkbox"/> Metal poisoning |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Epstein-Barr | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Extreme weight gain / loss | <input type="checkbox"/> Mental disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nerve disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fatigue | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Auto immune disorder | <input type="checkbox"/> Fever / chills | <input type="checkbox"/> Prostate condition |
| <input type="checkbox"/> Bloodclot / vessel disorder | <input type="checkbox"/> Fibro / polymialgia | <input type="checkbox"/> Renal insufficiency |
| <input type="checkbox"/> Binging / bulimia | <input type="checkbox"/> Headaches / migraines | <input type="checkbox"/> Sinus condition |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Skin condition |
| <input type="checkbox"/> Candida albicans | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Spleen / pancreas problems |
| <input type="checkbox"/> Chemical toxicity | <input type="checkbox"/> High / low blood pressure | <input type="checkbox"/> Sweats |
| <input type="checkbox"/> Cholesterol high / low | <input type="checkbox"/> Irregular menstrual cycle | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Toxicity |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Currently ___ months pregnant | <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low libido | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lung disorder | |

Have you been recently diagnosed with a major illness? _____

Have you recently had chemotherapy or radiation? _____

Do you use any of the following? How frequently?

- | | |
|---|---|
| <input type="checkbox"/> antibiotics (<i>Last time taken</i>) _____ | <input type="checkbox"/> prescription drugs (please list) _____ |
| <input type="checkbox"/> over-the-counter drugs _____ | _____ |
| <input type="checkbox"/> pacemaker <i>How long?</i> _____ | _____ |
| <input type="checkbox"/> prescribed birth control _____ | _____ |
| <input type="checkbox"/> recreational drugs _____ | <input type="checkbox"/> antidepressants (please list) _____ |
| <input type="checkbox"/> steroids _____ | _____ |
| <input type="checkbox"/> supplements (please list) _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Diet:

Using the following key, please indicate your dietary usage.
H = Heavy (5 - 7 times a week); M = Moderate (2 - 4 times a week);
L = Light (once a week or less); N = Never (Really, never!)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Chocolate | <input type="checkbox"/> Ice cream | <input type="checkbox"/> Salt |
| <input type="checkbox"/> Algae | <input type="checkbox"/> Dairy | <input type="checkbox"/> Junk food | <input type="checkbox"/> Smoothies |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Decaf coffee / tea | <input type="checkbox"/> Nuts / seed | <input type="checkbox"/> Soda |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Desserts | <input type="checkbox"/> Organic foods | <input type="checkbox"/> Soy |
| <input type="checkbox"/> Baked goods | <input type="checkbox"/> Eggs | <input type="checkbox"/> Pasta | <input type="checkbox"/> Sugar |
| <input type="checkbox"/> Beans | <input type="checkbox"/> Fatty foods | <input type="checkbox"/> Poultry | <input type="checkbox"/> Tobacco / cigarettes |
| <input type="checkbox"/> Bread | <input type="checkbox"/> Fish | <input type="checkbox"/> Popcorn | <input type="checkbox"/> Vegetables |
| <input type="checkbox"/> Caffeinated coffee | <input type="checkbox"/> Flax fiber | <input type="checkbox"/> Processed foods | <input type="checkbox"/> Water |
| <input type="checkbox"/> Caffeinated tea | <input type="checkbox"/> Fried foods | <input type="checkbox"/> Protein shakes | <input type="checkbox"/> Wheat / flour products |
| <input type="checkbox"/> Carbonated water | <input type="checkbox"/> Fruit | <input type="checkbox"/> Psyllium fiber | <input type="checkbox"/> White bread |
| <input type="checkbox"/> Cheese | <input type="checkbox"/> Gum | <input type="checkbox"/> Red meat | <input type="checkbox"/> Whole Grains |
| | | | <input type="checkbox"/> Yogurt |

Briefly describe your typical dietary intake for the following meals:

Breakfast _____

Lunch _____

Dinner _____

Snacks / desserts _____

Do you have any food cravings? No Yes _____

Lifestyle:

Are you currently under any excessive or unusual mental or physical stress? Please describe briefly:

Do you exercise? Yes No If yes, how do you _____

Are you, or have you been, addicted to:

Alcohol Coffee Sugar Drugs Prescription drugs Other _____

If there are other areas of your lifestyle or your life history (such as post-traumatic stress or sexual abuse) that you feel would be appropriate for us to know in order to better meet your needs, please comment in the space below. All information is strictly confidential.

I agree to give **24 Hours Notice** for cancellation of an appointment:

Client Signature: _____

Date: _____