

CLIENT INFORMATION & MEDICAL HISTORY
GENUINE BALANCE LLC COLON HYDROTHERAPY

PERSONAL HISTORY

Client Name: _____ Today's Date: _____

Home Address: _____ City: _____ State _____ Zip _____

Cell Phone(_____) _____ E-Mail : _____

Date of Birth: _____ Age: _____ Occupation: _____

Height _____ Weight _____ Female _____ Male _____ Marital Status _____

Emergency Contact Name and Phone _____

How were you referred to us? _____

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No If yes, for what? _____

Do you have a prescription for this visit? _____ If yes, do we have a copy on file? _____ If yes, Date _____

Is Colon Hydrotherapy part of a protocol that a healthcare professional has referred or prescribed for you? Yes No

If yes, Doctors and Type of Doctor _____

Reason _____ Date of referral/prescription _____

Do you have any of the following medical conditions? Please check all that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Abdominal Hernia | <input type="checkbox"/> Abdominal Surgery | <input type="checkbox"/> Abnormal Distension | <input type="checkbox"/> Acute Liver Failure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Aneurysm-All Types | <input type="checkbox"/> Cancer of the Colon | <input type="checkbox"/> Cardiac Condition |
| <input type="checkbox"/> Crohns Disease | <input type="checkbox"/> Colitis | <input type="checkbox"/> Dialysis Patient | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Fissures & Fistulas | <input type="checkbox"/> Hemorrhaging | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Intestinal Perforations |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Rectal/Colon Surgery | <input type="checkbox"/> Renal Insufficiencies |
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> AIDS | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Bladder Infections |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> BM Difficult | <input type="checkbox"/> Itching Anus |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Parasites |

Do you have any communicable Disease? Yes No If yes, explain: _____

Do you have any other health problems or medical conditions: Please list: _____

MEDICATIONS & SUPPLEMENTS

List all you now take regularly including over the counter: _____

Do you take digestive aids/laxatives? Yes No If yes, describe: _____

Are you on any steroids? Yes No Injections/oral _____

Are you on any blood thinners? Yes No Are you on any diuretics? Yes No

What was the most recent time you took antibiotics? _____ Why? _____

ADDITIONAL INFORMATION:

Describe your regular routine for exercise: _____

On a scale of 1 to 10 where 1 = can't get out of bed and 10=optimal energy, describe your normal energy level: _____

How many servings of vegetables do you eat per day? _____ How many servings of fruit per day? _____

How much water do you drink per day? _____

How much dairy do you eat per day? _____ How much meat do you eat per day or week? _____

Do you smoke? Yes No If yes, how much and how long? _____

Do you drink alcohol? Yes No If yes, how much and how long? _____

How often do you have a bowel movement? _____ skips days _____ 1 per day _____ 2 per day _____ 3 per day

Color and consistency of bowel movement _____

What do you hope to achieve from this colon hydrotherapy appointment? _____

Do you have specific concerns? Yes No If yes, explain: _____

My signature below indicates that I have honestly answered all of the questions above and supplied any additional relevant information within this intake form.

Date: _____

Client Name (Printed clearly)

Client Signature _____