Oasis Colon Hydrotherapy Client Information & Medical History

PERSONAL HISTORY:

Client Name:	Phone Number:	Today's Date:

Home Address:	City:	State:	Zipcode:

Date of Birth:	Age:	Occupation:

Height:	Weight:	Female:	Male:	Marital Status:

Emergency Contact Name:	Phone Number:

How did you find out about Oasis Colon Hydrotherapy:

MEDICAL HISTORY:

Are you currently under the care of a physician? (circle one) If yes, what for?

Y or N	

Do you have a prescription for this visit? (circle one) If yes, do we have a copy on file?

Y or N	Y or N

Is Colon Hydrotherapy part of a protocol that a healthcare professional has referred or prescribed for you?

Y or N	If yes, name and type of doctor:	Reason:	Referral Date::

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

Abdominal Hernia	Constipation	Diarrhea	Infectious Disease
Acute Liver Failure	Abdominal Surgery	Rectal Bleeding	Hepatitis B or C
Cardiac Conditions	Anemia	Abnormal Distension	Cancer of the Colon
Crohn's Disease	Colitis	Aneurysm	Intestinal Perforations
Fissures/Fistulas	Hemorrhaging	Dialysis patient	Renal Insufficiencies
Lupus	Pregnant	Hemorrhoidectomy	Bladder Infection
IBS/ Bloating	AIDS	Rectal/Colon surgery	Itching Anus
Parasites	Blood in stool	Diverticulitis	Hemorrhoids

Do you have any communicable diseases?

Y or N	If yes, explain:

Do you have any other health problems or medical conditions?

Y or N	**If yes, please list:**

MEDICATIONS & SUPPLEMENTS:

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

Do you take digestive aids/laxatives? Y or N	**If yes, describe:**

Are you on any Steroids? Y or N	**If yes, injections or oral?**

Are you on any blood thinners? Y or N	**Are you on any diuretics? Y or N**

When was the last time you were on an antibiotic and why?

ADDITIONAL INFORMATION:

Describe your regular routine for exercise:

On a scale of 1 to 10 where, 1 = can't get of bed and 10 = optimal energy. Rate your normal energy level:____
How many servings of vegetables do you eat per day?____ How many servings of fruit do you eat daily?_____
How much water do you drink daily? _____ How much dairy do you eat per day?_____
How much meat do you eat per day or week?_____

Do you smoke? Y or N	**If yes, how much daily and for how long?**

Do you drink alcohol? Y or N	**If yes, how much daily and for how long?**

How often do you have a bowel movement? Please share how many daily and if you skip days.

Color and consistency of bowel movements:_____
What do you hope to achieve from this Colon Hydrotherapy session?

Do you have specific concerns? Y or N	**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.

Client Name(Printed clearly):	**Client Signature:**	**Date:**