Holistic Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Occupation: _____

Gender: _____ Email: _____

Address: _____ Cell Phone: _____

City: _____ Zip Code: _____

First colon therapy? Y☐ N☐

If yes, when and where? _____

Are you under a doctor's care? Y___ N☐

What are you being treated for? _____

Doctor's Name, Office Location, and Phone: _____

_____

Medications: _____

_____

_____

Supplements: _____

_____

_____

Please list all recent surgeries: _____

_____

_____

Bowel Health

How many bowel movements do you have per day? _____

If you don't have daily bowel movements, how many do you have per week? _____

Do you strain to have a bowel movement? _____

Does it feel complete? _____

Are there signs of blood? _____

Are there signs of mucous? _____

Is there a strong odor? _____

Typical stool color: _____

Do you use laxatives? If yes, what type and how often? _____

Contraindications

Please check all that currently apply to you:

- ❑ Congestive Heart Failure
- ❑ Severe Cardiac Disease
- ❑ Tumor in the Rectum or Large Intestine
- ❑ Aneurysm
- ❑ Vomiting
- ❑ Recent Colonoscopy (at least 12 days post colonoscopy)
- ❑ Abortion (less than 6 months)
- ❑ Miscarriage (less than 4 months post-op)
- ❑ Renal Insufficiency
- ❑ Take Blood Medication
- ❑ Kidney Dialysis
- ❑ Severe Anemia
- ❑ Active Aneurysm
- ❑ Active Internal Bleeding
- ❑ GI Hemorrhage/Perforation
- ❑ GI Band
- ❑ Severe Hemorrhoids
- ❑ Epilepsy
- ❑ Ulcerative Colitis
- ❑ History of Seizures
- ❑ Crohn's Disease
- ❑ Cirrhosis
- ❑ Diverticulitis
- ❑ Breast Feeding
- ❑ Hepatitis A, B, C
- ❑ Pregnancy
- ❑ Carcinoma of the Colon or Rectum
- ❑ Compromised Immune System at the Present Time
- ❑ Fissures/Fistulas

- ❑ Current GI Infection
- ❑ Abdominal/Inguinal Hernia
- ❑ Rectal Bleeding
- ❑ Colon Surgery
- ❑ Strong Abdominal Pain
- ❑ Recent Abdominal Surgery (at least three months post-surgery)
- ❑ Recent Hernia Surgery
- ❑ Taking Blood Pressure Medication
- ❑ Taking Medication to Control Diabetes

Please further describe any conditions checked above: _____

_____

Existing Conditions

Please check all that currently apply to you:

- ❑ Anxiety
- ❑ Anemia
- ❑ Allergies
- ❑ Arthritis
- ❑ Asthma
- ❑ Heart Disease
- ❑ Kidney Stones
- ❑ Liver Disease
- ❑ Abdominal Gas
- ❑ Bloating/Indigestion
- ❑ Irritable Bowel Syndrome
- ❑ Colitis
- ❑ Celiac Disease
- ❑ Constipation
- ❑ Gallstones
- ❑ UTI
- ❑ Diabetes
- ❑ Eating Disorder
- ❑ Extreme Weight Loss/Gain
- ❑ Ulcer
- ❑ Parasites
- ❑ Heartburn/Acid Reflux
- ❑ Worms in Stool
- ❑ Polyps

- ❑ Active Hemorrhoids
- ❑ Skin Condition

Please further describe any conditions checked above: _____

_____

Lifestyle

Are you currently under any unusual mental stress?

_____

Do you exercise? _____

What brings you in today and what do you hope to resolve? _____

_____

How did you hear about us?

- ❑ Google Search
- ❑ Facebook
- ❑ Family or Friend
- ❑ Other (Please Specify) _____

Cancellation Policy & Disclaimer

- ❑ Cancellation or changes to appointment day and time must be made within 24 hours in advance of scheduled appointment. **A $50 fee will be charged if an appointment is missed or cancelled at the last minute.** If you need to change or cancel your appointment, please call or text 860-481-2702. Please do not cancel using email.

- ❑ This service is not intended to replace the relationship with your primary care provider and any information we provide is not intended in any way as medical advice. The information covered should be considered as shared information and knowledge from your therapist's education, training, and experience. Your therapist encourages you to incorporate new information along with the effectiveness of your service and the fundamental role of diet, exercise, supplements, and stress management therapy. We encourage you to make your own health care decisions based upon your research and in

partnership with your primary care provider, ND, or MD. **The information and services provided are not used to prescribe, diagnose, or treat health problems or diseases. Your service is not considered a substitute for medical care.**

- ❑ I have chosen to have this service within my own will and will in no way blame the therapist at The Colonic Institute for any wrongdoing from the general steps involved in providing this service. I realize that detoxification symptoms may occur and is a natural reaction if it does occur due to the effects of this service.

  I have read and understand the above information:

  _____ (Signature)