# A Touch From Heaven

Colon Hydrotherapy Client Information

Name:_______________________________________________

Address: _______________________________________________

City: _______________________ State:________ Zip:__________________

Phones: - Home:____________________ Office: ____________________ Cell: ____________________

Email Address (please write clearly): _______________________________________________

Date of Birth_______________ How did you find out about us? ______________________________

Emergency Contact: ________________________________ Phone Number: ____________________

Have you had a colonic before? ______________ If so, when? ______________________________

How many times a day do you have a bowel movement?____________

Have you ever been treated for pathology of the colon? ______________________________

Have you ever observed blood in your stool?_________ Have you ever observed mucus in your stool?________

Do you experience diarrhea or constipation? Please describe: ______________________________

What is the consistency of your Stool?: Formed __ Unformed__ Hard__ Liquid __ Other__

What is the size of your stool?: Small__ Medium__ Large__ Pencil thin__ Flat__ Pebbles __ Other __

When you eliminate what would you say you feel?: Complete__ Incomplete__ Explosive__ Strained__

How long do you think your transit time is before you eliminate?
12 hours__ 1 day__ 2days__ 3 days__ you don't know__

What color has your stool been? Light Brown__ Medium__ Dark Brown__ Black__ Red__ White__

Do you have any immune disorders? HIV+ _____ AIDS______ Other ______________________

Please describe any surgery: _______________________________________________

Do you have high blood pressure? ______________________ Low blood pressure? ____________________

Please list the foods you've eaten in the past 24 hours:

Breakfast:______________________________ Lunch:______________________________

Dinner:______________________________ Other: ______________________________

What snacks & food do you crave______________________ Do you eat late at night?__________________

Is your diet high in fiber or bulk?______________________ Do you take Laxatives? __________________

When was the last time you took antibiotics? ______________________________

How long did you take antibiotics for ______________________________

How many glasses or ounces of liquid do you drink daily?: ___________ Coffee ________Alcohol

________Soda ________Black Tea _________ Sugar drinks _________ Water ________ Expresso

Do you sleep well? ______________________________ How many hours nightly?______________

Do you have a stressful life?______________________________

What do you do to relieve stress?______________________________

*Please complete the back side of this form…* ♥