

# Client Health Questionnaire

## **CONTACT INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ (hm) \_\_\_\_\_ (wk) \_\_\_\_\_ (mbl)

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Sex: Male  Female  Marital Status:  Married  Single  Other

Children: \_\_\_\_\_ Ages: \_\_\_\_\_

Occupation: \_\_\_\_\_

Hobbies & Activities: \_\_\_\_\_

Emergency Contact Information: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently under a doctor's care?  Yes  No ( If YES, explain below)

Date of last complete Physical Exam: \_\_\_\_\_ Results: \_\_\_\_\_

Is your Physician aware of you receiving colon hydro-therapy?  Yes  No

Have you ever had colon hydro-therapy?  Yes  No (If YES, explain where and when below)

How did you learn of our services? \_\_\_\_\_

Please state your reasons for and expectations from receiving colon hydro-therapy:

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