Kristin Darfus
I-ACT Certified Colon Hydrotherapist

Confidential Health Questionnaire

Date _____

Name _____ DOB _____

Address _____

City _____ State_____ Zip _____

Telephone Number ___(_____)_____ Home/Cell (circle one)

Telephone Number ___(_____)_____ Home/Cell (circle one)

For future appointments, would you like to receive text message reminders? YES/NO

Email Address _____

How did you hear about Pure Health and Wellness Colon Hydrotherapy? _____

_____.

Have you received colon hydrotherapy before? YES/NO Date _____

What is your reason for treatment? _____

What is your overall health goal? _____

General Health Questions

Height _____ Weight _____ Occupation _____

Are you under the care of a physician? _____

How often do you eliminate? _____ times daily _____ times weekly

My bowel movements are: (circle one or more)

Spontaneous Occur only after eating Effortless Require straining

Painful Incomplete

Do you regularly use any of the following? (Check all that apply)

Fiber ____ Bentonite ____ Laxatives ____ Enemas ____ Enzymes ____ Probiotics ____

Stool Softeners ____ Antacids ____ Other (please list) _____

Do you have family history of intestinal problems? YES/NO
If so, what were the issues? _____

Surgeries/Recent Medical Information

Have you had any surgeries in the last 6 months? YES/NO

If yes, please specify: _____

Have you had any of the following? (check all that apply)

Abdominal Hernia ____
Abdominal Surgery ____
Abnormal Distention ____
Acute Liver Failure ____
Anemia ____
Aneurysm (all types) ____
Barium X-Ray ____ When?_____
Carcinoma of Colon ____
Colonoscopy ____ When?_____
Crohn's Disease ____
Colitis ____
Dialysis ____
Diverticulosis/Diverticulitis ____
Hemorrhaging ____
Hemorrhoidectomy ____
Intestinal Perforations ____
Lupus ____
Colon Surgery ____
Renal Insufficiency ____
Hypertension ____

Are you currently pregnant? YES/NO Due Date _____

Please indicate **ALL MEDICATIONS** below:

Herbs, vitamins, and supplements: _____
_____.

Any over the counter medications: _____
_____.

Any prescription medications: _____
_____.

Do any of your medications slow or speed your elimination? YES/NO

If yes, which ones? _____

Diet

Percentage of diet from fruits/vegetables? ____ % Raw/living foods? ____ %

What percentage of meals are not prepared at home? ____ %

What do you crave? Sugar ___ Salt ___ Carbonation ___ Chocolate ___ Fats ___

Do you eat any of the following on a regular basis? (circle if the answer is YES)

Meats: Beef Chicken Pork Lamb Fish Cold Cuts Wild Game Turkey

Dairy: Cheese Cream Cheese Ice Cream Sour Cream Cottage Cheese Eggs Whipping Cream Yogurt Milk Kefir

Sauces/Oils: Worcestershire MSG Ranch Miracle Whip Soy Sauce Mayonnaise Olestra/Olean Olive Oil Butter Margarine Ketchup Mustard

Additives: Salt MSG Seasonings Soy Splenda Honey Table Sugar Artificial Sweeteners Diet Sodas/Soda

Snack Foods: Pizza White Bread Waffles/Pancakes Pie Popcorn Candy Cereal Cookies Doughnuts French Toast English Muffins Bagels Cake Pastries French Fries Chips Pretzels

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Eating Behaviors

Please circle any behaviors you experience in regards to food:

Constipation Overeating Binge Eating Anorexia Bulimia Late Night Eating

Eating when… (circle all that apply):

Fatigued In Pain Emotionally Upset Not Hungry Stressed Happy

Please circle any diet restrictions:

Vegetarian Vegan Pescatarian Raw Foodist Gluten Free Lactose Intolerant

Irritable Bowel Syndrome Diet Program Other: _____

Fluids

What is your total fluid intake per day? _____

Circle the beverages that you drink:

Water: Tap Distilled Reverse Osmosis Alkalized other

Juices: Raw Juices (homemade or store bought) Bottled Juices

Alcohol: Beer Wine Liquor

Teas/ Coffees: Herbal Tea Iced Tea Other Teas Coffee Espresso

Other: Soft Drinks Diet/Regular Drinks Dairy

Do you own a juicer? YES/NO

Do you consume liquids during meals? YES/NO

Emotional/Mental States

Circle any symptoms that you experience:

Depression Irritability Restlessness Codependency Grief Anger Hurt

Sadness Forgetfulness Anxiety Fearfulness Despair Mental Confusion

Obsessive Compulsive Behavior Bipolar Disorder

Are you under excessive stress? YES/NO

How do you respond to stress? _____.