

Robert Jordan Health Services
6810 Tilden Lane
Rockville, Maryland 20852
301-468-3962

Colon Hydrotherapy Health History Intake Form

Date of initial visit _____

Name _____

Address _____

City _____ State _____ Zip code _____

Email _____

Phone (day) _____ (eve) _____

Occupation _____ Employer _____ How long _____

Age _____ Height _____ Weight _____ Date of Birth _____

How were you referred? Friend (Name) _____ Phone book _____ Ad _____

Coupon _____ Flyer _____ Doctor _____ Other _____

What is the purpose of your visit? _____

Are you now under the care of a medical doctor, chiropractor, naturopathic doctor, Chinese medicine doctor, acupuncturist, or any other health care professional?

Yes _____ No _____ Doctor's name _____

If yes, please explain what for what you are being treated: _____

Major physical complaint: _____

List all medications and supplements you are currently taking: _____

List all known allergies: _____

How frequently do you have a bowel movement (BM)?

3x/day _____ 2x/day _____ 1x/day _____ 4x/week _____ 2-3 times/week _____ Other _____

Do you have to strain to have a BM? Yes _____ No _____

Do you use laxatives? Yes _____ No _____ Natural _____ Synthetic _____

Do you have hemorrhoids? Yes _____ No _____ Rectal bleeding? Yes _____ No _____

Have you had any of the following procedures or surgeries: Recent barium enema _____

Colonoscopy _____ Sigmoidoscopy _____ Rectal surgery _____ Colon Surgery _____

Appendectomy _____ Gallbladder _____

List other surgeries: _____

Page 2, Colon Hydrotherapy Health History Intake Form

Significant Medical History: Do you have, or have you had any of the following? Please check "Yes" or "No".

- High blood pressure: Yes _____ No _____
- Heart trouble: Yes _____ No _____
- Diverticulosis: Yes _____ No _____
- Diverticulitis: Yes _____ No _____
- Cancer of the colon: Yes _____ No _____
- Colitis: Yes _____ No _____ (spastic _____ ulcerative _____ mucus _____)
- Hemorrhoids: Yes _____ No _____ (internal _____ protruding _____)
- Kidney disease: Yes _____ No _____
- Blood in stool: Yes _____ No _____
- Recurrent or constant pain in abdomen: Yes _____ No _____
- Other (please describe): _____

Are you pregnant? Yes _____ No _____
If yes, which trimester? First ___ Second ___ Third ___ Due date: _____

Please check if you currently have the following:

- | | |
|---|---|
| <input type="checkbox"/> Abdominal discomfort | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Increased body odor |
| <input type="checkbox"/> Aches, pains, stiffness | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Indigestion after meal |
| <input type="checkbox"/> Burping, frequent | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Lack of vitality |
| <input type="checkbox"/> BM, painful or difficult | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Burning, itching anus | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Coated tongue | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Protruding abdomen |
| <input type="checkbox"/> Cravings for food | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sour stomach |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Stool (very foul odor) |
| <input type="checkbox"/> Extreme stress | <input type="checkbox"/> Underweight |
| <input type="checkbox"/> Gas (very foul odor) | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Greasy foods upset | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Gas after eating | |

Anything else we should know about you? _____

In case of an emergency, call: _____ Phone _____

This is my true personal history. _____

Client's signature