COLORADO COLONICS INC.

Personal History Form

Name____ Date___________________________

Address_________________________________ City_____________ State___________ Zip_________

Home Phone_______________________________ Work Phone_________________________________

Cell Phone________________________________E-Mail Address_______________________________

Birthdate_______________________ Age____________________ Sex___________________________

Marital Status___________________ Spouse_________________ # of Children____________________

Occupation_______________________________ Referred by___________________________________

Please circle all of the following symptoms which you now have or have had previously. Be as thorough as possible. Your health history is confidential!

General Symptoms
Headache
Fever
Chills
Sweats
Fainting
Allergy
Dizziness
Convulsions
Loss of Sleep
Fatigue
Nervousness/Depression
Loss of Weight
Numbness in: ________

Eyes, Ears, Nose, Throat
Failing Vision
Near Sightedness
Far Sightedness
Crossed Eyes
Eye Pain
Deafness
Earache
Ear Noises
Ear Discharge
Nose Bleeds
Nasal Obstruction
Nasal Drainage
Sore Throat
Swollen Tonsils
Enlarged Lymph Glands
Enlarged Thyroid
Hoarseness
Colds
Sinus Infection
Hay Fever
Asthma
Dental Decay
Gum Trouble

Skin
Skin Eruptions
Itching
Bruises Easily
Dryness
Boils
Varicose Vein
Sensitive Skin
Hives or Allergy

Respiratory
Chronic Cough
Spitting Up Phlegm
Spitting Up Blood
Chest Pain
Difficult Breathing

Cardio-Vascular
Rapid Beating Heart
Slow Beating Heart
High Blood Pressure
Low Blood Pressure
Pain Over Heart
Heart Attack
Swelling of Ankles
Poor Circulation

Muscle, Bone, & Joint
Stiff Neck
Backache
Swollen Joints
Tremors
Painful Tailbone
Foot or Ankle Trouble
Pain in: shoulders, arms, elbows, hands, hips, legs, knees, feet, other?________
Hernia
Faulty Posture

Genito-Urinary
Frequent Urination
Painful Urination
Blood in Urine
Pus in Urine
Kidney Trouble
Inability to Control Urine
Prostate Trouble

Gastro-Intestinal
Poor appetite
Excessive Hunger
Difficult Digestion
Belching or Gas
Distention of Abdomen
Nausea
Vomiting
Vomiting of Blood
Pain Over Stomach
Pain Over Lower Abs
Constipation
Diarrhea
Colon Trouble
Hemorrhoids or Piles
Rectal Bleeding
Bloody Stools
Intestinal Worms
Liver Trouble
Gall Bladder Trouble
Jaundice

For Women Only
Painful Menstrual Periods
Excessive Menstrual Flow
Hot Flashes
Irregular Cycle
Cramps or Backache
Miscarriage
Vaginal Discharge
Lumps in Breast
Menopausal Symptoms

Recent Symptoms?

Circle Any of the Following Conditions You Have Had:

Alcoholism	Diabetes	Gout	Other_________	Tuberculosis
Anemia	Diphtheria	Heart Problems	Pleurisy	Typhoid Fever
Appendicitis	Eczema	Malaria	Pneumonia	Ulcers
Arteriosclerosis	Emphysema	Measles	Polio	Venereal Infection
Arthritis	Epilepsy	Mental Disorder	Rheumatic Fever	Whooping Cough
Cancer	Fever Blisters	Mumps	Scarlet Fever	
Chicken Pox	Flu	Multiple Sclerosis	Stroke	
Colitis	Goiter	Nervous Breakdown	Small Pox	

Have you ever: Please describe the what and when of any situation below:

Had any unusual accidents of falls? ____

____

Had any bone fractures? ____

____

Been knocked unconscious? ____

____

Had any surgical operations? ____

Habits:

Sleep- Hours Daily? ______________________ Is it enough?______________________
Exercise- Hours Daily? ______________________ Is it enough?______________________
Fresh Air- Hours Daily? ______________________ Is it enough?______________________
Water- Hours Daily? ______________________ Is it enough?______________________
Food- Too much of little?______________________ Use proper food combining?______________________
Positive Attitude- Consistent? ____
Emotions- Do you feel they are in balance?____

Do you use any of the following on a daily basis?

Alcohol
Coffee
Tea
Tobacco
Supplements:
- Vitamins
- Minerals
- Herbs

Drugs/Medications- What kind and what for? ____
Other:____

Most recent medical service/hospitalization? For what, where and when? ______________________________
____

Have you ever had professional colon hygiene/lower bowel evacuation sessions before? No__________ Yes ____________
Where and when?____

Your primary reason for using this service?____
____

Your #1 health goal or concern at this time? ____
____

____
Client Signature