Richmond Hill Natural Therapies
Confidential Case History
Colonics

Last Name	First Name	Address		
City	Postal Code	Today's date	Phone # (home)	Phone # (work)
Date of birth	Occupation	Is this a motor vehicle accident?		
How did you hear about us?	Do you have extended insurance for massage?	1st colonic ever?		
Medical Doctor's name	Phone #	Email Adress:		

Reason for consulting the office:

- ☐ I have no symptoms and feel well. I am interested in strategies to help me continue to feel well or even better.
- ☐ I have a specific problem and require help with this problem only.
- ☐ After my specific problem has been relieved, I am interested in strategies to ensure the problem does not return.

Current Health Condition

What are your major complaints?	
When did it start?	Have you had a similar problem in the past?
The condition is: constant occasional getting worse	The condition is interfering with: work sleep daily routine other
Have you consulted others regarding the condition?	Have you had xrays taken?
What makes your condition worse? better?	
Have you ever done a detox?	Please list surgeries and major illnesses
List any medications used & why	Any other health complaints?

Richmond Hill Natural Therapies
Colonic Case History page 2

Do you smoke?	**Stool Status**: hard__ soft __ loose__ shape_____ length_____ width_____ floats__ sinks__

slides out easily__must be pushed out__ Gas: Excessive __ Belching__
Regularity: How often and when:_____
Colour: light__ medium__ dark__ black__ mucus__ blood__ strong odour__
Anal itching: continuous__intermittent__ at night__
Protruding rectum__ only after a bowel mvmnt__ constant urge to go_____

Are you allergic to any aromatherapy latex, plastic or nut oils?	Are you pregnant? _____months	Do you have pets?

Have you ever suffered from any of the following:

Allergies	Diabetes	Hepatitis	Sciatica
Amenorrhea	Diarrhea	High blood pressure	Sinusitis
Angina	Diverticulosis	Infective arthritis	Spastic colon
Arthritis	Dizziness	Insomnia	Stress
Asthma	Edema (swelling)	Liver disease	Swelling
Athletes foot	Emotional distress	Loss of sex drive	Ulcer
Breast problems	Excessive urination	Low back pain	Uterus prob
Bronchitis	Fatigue	MS	Vaginitis
Bursitis	Fibrositis	Operations (recent)	Yeast
Cancer	Anal fissure	Osteoarthritis	(candida)
Celiac disease	Gout	Parkinsons	
Cold hands/feet	Headaches	Parasites	
Crohn's disease	Hernias	Peptic ulcers	
Colitis	Heart problems	Polyps	
Cramps	Heart burn	Prolapsed rectum	
Depression	Hemorrhoids	Rheumatoid arthritis	

Plse check any symptoms you experience at least once or twice per week:

Cold hands/feet	Dark circles under eyes	Difficulty concentrating
Difficulty falling asleep	Difficulty sleeping	Dry mouth
Easily irritated	Excessive urination	Faintness/dizziness
Fatigue	Feeling fearful	Feeling tense or nervous
Grinding teeth	Heart racing	Heavy feeling in arms/legs
Hot flashes	Itching (anal or other)	Loss of sexual desire
Mind going blank	Nausea or upset stomach	Overeating
Poor appetite	Shakiness/trembling	Sore muscles
Tight muscles	Trouble getting breath	Twitches/ticks/spasms
Uncontrollable temper	Voice quavering/shaking	

Other ailments not listed:

Richmond Hill Natural Therapies
Colonics Case History page 3

Level of wellbeing at this time: 0—10 ____	Date of last Physical:

Brief family history of disease:

	Yes	No	
Are you on a nutritional program now?	____	____	type:_____
Do you eat a high fiber diet?	____	____	
Are you taking a probiotic (acidophilus)	____	____	brand:_____
Are you taking flax or fish oils?	____	____	brand:_____
Are you eating organic foods?	____	____	what %:_____

What is your blood type? _____

Please list any supplements you take:_____
_____

Habits:	**Heavy**	**Moderate**	**Light**
Alcohol			
Coffee			
Cola/carbonated drinks			
Tea			
Drugs/medication			
Exercise			
Sleep			
Sugar			
Red Meat (how well cooked)			
Sushi (raw fish or just veg)			
Vegetables/fruits			
Grains			

Where do you live: City___ Country___
Water supply: Tap___ Well___ Bottled___ Reverse Osmosis___ Distilled___
How many glasses per day? _____

Metabolism: Underweight___ Overweight ___ Sluggish after meals___
Headache after meal___ Low blood sugar___ Diabetes___ Obesity___
Anorexia___ High Cholesterol___

We do require 24 hours notice to cancel an appointment (except in cases of illness and emergencies). Please give us ample notice in order to avoid cancellation fees. By signing below I consent to receive Colon Hydrotherapy treatments from_____Therapist. Signed_____
Plse give us feedback during your treatment. You are in control.