

COLON HYDROTHERAPY CLIENT INFORMATION

No.:
(For Office use)

Date:

Name:

Date of birth:

Age:

Sex:

H.K.I.D. No. /Passport No.:

Address:

Telephone No.: Residence :
Office :
Mobile phone :
Email :

Occupation (nature of work):

Language preferred:

Referred by:

OPTIMUM HEALTH CENTRE: 2/F Prosperous Commercial Building
54-58 Jardine's Bazaar
Causeway Bay, Hong Kong
Tel : (852) 2577-3798
Fax : (852) 2890-8469
Email : optimum@netvigator.com
Web Site : www.naturalhealing.com.hk

HONG KONG COLON HYDROTHERAPY CENTRE:
7/F Coin Organize Centre
13-15 Pennington Street
Causeway Bay, Hong Kong
Tel : (852) 2890-6800
Fax: (852) 2890-1063
Email : colonic@netvigator.com
Web Site : www.naturalhealing.com.hk

REASONS FOR SEEKING TREATMENT:

- ___ Don' t know
- ___ Directed by someone else
- ___ Total body rejuvenation program
- ___ Weight loss program
- ___ General cleansing program
- ___ Other reasons as following:

Please check items that you experience at least once or twice per week.

- | | |
|-----------------------------------|----------------------------------------|
| ___ Faintness/Dizziness | ___ Overeating |
| ___ Hot flashes | ___ Loss of sexual desire |
| ___ Voice quivering/shaking | ___ Excessive urination |
| ___ Dry mouth | ___ Cold hands and feet |
| ___ Tightness of jaw | ___ Blushing |
| ___ Soreness of muscles | ___ Twitches, ticks, spasms |
| ___ Weakness in parts of the body | ___ Lump in throat |
| ___ Pains in heart or chest | ___ Stuttering |
| ___ Excessive alcohol | ___ Grinding of teeth |
| ___ Smoking | ___ Heavy feeling in arms and legs |
| ___ Itching | ___ Heart racing |
| ___ Sweaty palms | ___ Tightness of stomach |
| ___ Feeling tense or nervous | ___ Trouble getting your breath |
| ___ Shakiness / Trembling | ___ Nausea or upset stomach |
| ___ Bad dreams | ___ Extreme fear of places or events |
| ___ Mind going blank | ___ Feeling fearful |
| ___ Difficulty sleeping | ___ Feeling inferior to others |
| ___ Poor appetite | ___ Difficulty concentrating |
| ___ Easily annoyed or irritated | ___ Thoughts of ending your life |
| ___ Easily crying | ___ Worrying or stewing about things |
| ___ Loss of sexual function | ___ Loss of interest in things |
| ___ Fatigue | ___ Uncontrollable outbursts of temper |

Indicate your general feeling well being at this time: _____
(0 indicates the worst general feeling. 10 indicates the best you could possibly feel.)

Length of time since your last physical examination. _____

Please give a brief family history of illness:

List all medications you are taking presently and medications that you have taken over a long period of time:

Name of drugs:	Dosage:	Reason for taking the Medications: does it help?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

	Yes	No	If yes, please list
Are you on a nutritional diet program?	_____	_____	_____
Do you eat a high fiber diet?	_____	_____	_____
Are you taking colon flora? (e.g. acidophilus)	_____	_____	_____
Does it affect your bowel movements?	_____	_____	_____
Do you take supplements?	_____	_____	_____

Please list any allergies you have: _____

Please list any surgeries and dates: _____

Describe any special problems: _____

METABOLIC HISTORY

Underweight	_____	Diabetes	_____
Overweight	_____	High Cholesterol	_____
Sluggish after meals	_____	Obesity	_____
Headaches after meals	_____	Anorexia	_____
Low Blood Sugar	_____		

HABITS: Please check the appropriate amount for the following:

	Heavy	Moderate	Light
Smoking	_____	_____	_____
Alcohol	_____	_____	_____
Coffee	_____	_____	_____
Cola Drinks	_____	_____	_____
Tea	_____	_____	_____
Drugs	_____	_____	_____
Exercise	_____	_____	_____
Sleep	_____	_____	_____
Sugar	_____	_____	_____
Red Meat	_____	_____	_____
Vegetables	_____	_____	_____
Grains	_____	_____	_____
Fruits	_____	_____	_____
WATER YOU DRINK:	boiled tap _____	filtered _____	bottled _____
	distilled _____		

Amount of Water Consumed Daily (not counting juice, tea, coffee, etc.)

Describe your daily diet (briefly):

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

STOOL STATUS (regularly)

hard _____ firm _____ soft _____ loose _____

smooth _____ cracks _____

Shape _____ Length _____ Width _____

Does it sink _____ or float _____ small bubbles on it _____ or large _____

Ability:

Does it slide out _____ or must push out _____ forcefully _____

Regularity: How often and when: _____

Color: light _____ medium _____ dark _____ black _____

mucus _____ blood _____ strong odor _____ fluid _____ jelly-like _____

Gas: excessive _____ belching _____ heartburn _____ pressure on chest _____

Anal itching: continuous _____ intermittent _____

Protruding rectum: continuous _____ only after a bowel movement _____

Is there frequent or constant urge for a bowel movement? _____

THANK YOU FOR TAKING THE TIME TO FILL THIS OUT