

# Confidential Patient Case History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Why do you wish to have a colonic? \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

Any other complaints? \_\_\_\_\_

Please underline all of the following symptoms which you have now or have had previously.

### GENERAL SYMPTOMS

- |                            |                       |                         |
|----------------------------|-----------------------|-------------------------|
| Headache                   | Liver trouble         | Chest Pain              |
| Dizziness                  | Gall bladder trouble  | Difficulty breathing    |
| Sore throat                | Jaundice              | Rapid beating heart     |
| Sinus infection            | Nausea                | Slow beating heart      |
| Psoriasis                  | Pain over stomach     | High blood pressure     |
| Eczema                     | Distention of abdomen | Low blood pressure      |
| Frequent urination         | Constipation          | Pain over heart         |
| Painful urination          | Diarrhea              | Colon trouble           |
| Inability to control urine | Hemorrhoids           | Gastroenteritis/Colitis |
| Pain between shoulders     |                       |                         |

### Medical Attention for Chief Complaint:

Name and address of doctor \_\_\_\_\_

List surgical operations and years: \_\_\_\_\_

Drugs you now take \_\_\_\_\_

### Have you ever:

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| Been knocked unconscious?              | Y | N | Been diagnosed with Diverticulitis?     | Y | N |
| Been treated for spine or nerve issue? | Y | N | Been diagnosed with Crohne's?           | Y | N |
| Had a fractured bone?                  | Y | N | Been diagnosed with ulcerative colitis? | Y | N |
| Been hospitalized other than surgery?  | Y | N | Been diagnosed with spastic colon?      | Y | N |
| Been diagnosed as having Hepatitis?    | Y | N | Had bleeding from the rectum?           | Y | N |
| Worked in a toxic environment?         | Y | N | Been diagnosed with endometriosis?      | Y | N |
| Have you ever had eating disorder?     | Y | N | Do you take vitamins or minerals?       | Y | N |
| Are you currently pregnant?            | Y | N |   |   |   |

### HABITS      Heavy   Moderate      Light   None

- |          |       |       |      |      |
|----------|-------|-------|------|------|
| Alcohol  | ----- | ----- | ---- | ---- |
| Coffee   | ----- | ----- | ---- | ---- |
| Tobacco  | ----- | ----- | ---- | ---- |
| Drugs    | ----- | ----- | ---- | ---- |
| Exercise | ----- | ----- | ---- | ---- |
| Sleep    | ----- | ----- | ---- | ---- |
| Appetite | ----- | ----- | ---- | ---- |

\_\_\_\_\_  
Signature of patient