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)_____ Ad_____

Pathways Magazine____ Yelp _____ Doctor (Name) _____ Others_____

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: _____

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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 <u>currently</u> have the following:

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

Anything else we should know about you? _____

_____

In case of an emergency, call: _____ Phone _____

This is my true personal history. _____
Client's signature