Nature's Call Detox & Cleansing Spa
Client Information

Personal Information

Date:_____ Age: _____

Name:_____

Address:_____

_____

City:_____ Province:_____

Postal Code:_____

Phone: (h)_____ (cell)_____

Occupation:_____

Date of Birth_____

Height:_____ Weight_____

Marital Status:_____

Family Physician_____

Have you ever had a colonic? Y N

If so when?_____

Where?_____

Who referred you here?_____

In case of emergency, contact:

_____

Physical Complaints:

Health Information

Allergies?? When??

_____

_____

_____

Medications and Supplements you take:

_____

_____

_____

Elimination Assessment
Bowel Movements:

_____X per day _____X per week

Do you use a stool softener or laxative?

_____ Yes _____ No _____ Often

Stools are:

_____ Soft _____ Hard ____Diarrhea

_____ Difficult to pass ____ Loose

_____ Foul Smelling _____ Little odor

Stool Colour:

_____ Greenish _____ Brown

_____ Yellow _____ Very dark or black

_____ Blood _____ Mucous

Health Information Continued

Intestinal Gas:

_____ Daily____ Occasionally _____ Painful

_____ Excessive _____ Foul Odor

Trouble initiating a bowel movement?
YES NO
Are your stools big or hard??
YES NO

Do you have abdominal pain or cramping during a bowel movement?
YES NO
How often? _____

Have you had problems in the past or present with:

STOMACH LIVER PANCREAS

INTESTINES GALLBLADDER

Have you been diagnosed with:

		When??
Appendicitis	_____	_____
Hemorrhoids	_____	_____
Diverticulosis	_____	_____
Spastic Colon	_____	_____
Bowel Disorder	_____	_____
Cancer	_____	_____

If yes, have you had:

Chemotherapy	_____	_____
Radiation	_____	_____
Surgery	_____	_____

Could you be pregnant? Y N

Have you had rectal bleeding?

YES NO When?_____

Have you had internal bleeding?

YES NO When?_____

Do you eat or drink the following?

High fiber diet	YES	NO
Coffee	YES	NO
Soda	YES	NO
Filtered Water	YES	NO
Alcohol	YES	NO
Sugar	YES	NO
Meat	YES	NO
Fast Foods	YES	NO
Dairy products	YES	NO
Wheat products	YES	NO

Have you ever had a barium enema?

YES NO When? _____

Do you experience the following symptoms?

□ Nausea after eating
□ Food regurgitates
□ Fullness after meals
□ Disinterest in foods
□ Pain or burning sensation after meals
□ Bloating
□ Burping

How many meals do you eat each day?

□ Breakfast □ Lunch □Dinner

Do you eat on the run?
YES NO

How do you feel about the food you eat?

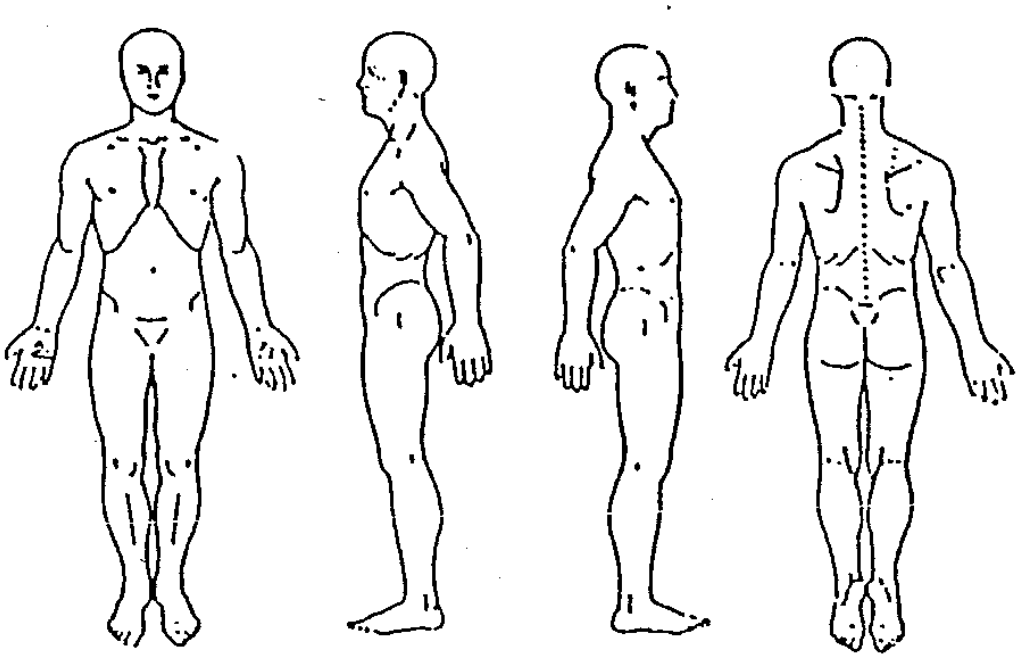
_____

Have you been tested for food allergies?
YES NO
Any findings? _____

What foods do you crave?
_____

_____

INDICATE THE AREAS IN WHICH YOU ARE PRESENTLY EXPERIENCEING PROBLEMS



HEALTH PROFILE

DO YOU HAVE?

( ) BLURRED VISION
( ) HISTORY OF GALLSTONES
( ) DRY MOUTH & EYES
( ) SWOLLEN EYELIDS
( ) MOODS OF DEPRESSION
( ) HEADACHES
( ) BRUSIES
( ) SWOLLEN ANKLES
( ) JOINT STIFFNESS
( ) PAIN BETWEEN THE SHOULDER BLADES
( ) HAIR LOSS
( ) MUSCLE CRAMPS
( ) POOR SLEEP HABITS
( ) POOR MEMORY
( ) NOSEBLEEDS
( ) FEVERS
( ) REDUCED APPETITE
( ) ITCHING ANUS
( ) PERIODS OF VOMITING
( ) COLDS OFTEN

DO YOU:

( ) EAT WHEN NERVOUS?
( ) GAIN OR LOSE WEIGHT EASILY?
( ) GET JITTERY WHEN MEAL DELAYED?
( ) WORRY?
( ) FEEL INSECURE?

WHAT IS YOUR BLOOD TYPE? O A AB B

FOOD (IN PERCENTAGE OF DIET) 10%, 50%, 90%
MEAT, FRUITS, VEGTABLES, GRAINS, BEANS/LEGUMES

ORGANIC/NON-ORGANIC % OF DIET

FRESH AND RAW VS. COOKED RAW

JUNK FOOD % OF DIET (CANDY, COOKIES, TAKE OUT, POP, DESSERTS)

Do you have any mercury (silver) fillings?

YES NO How many? _____

SPECIFIC COMPLAINTS:

WHAT AILMENT BROUGHT YOU HERE? _____

HOW DID YOU HEAR ABOUT THIS CLINIC?

VITALITY EYE FOR FUTURE FRIEND INTERNET OTHER

I the undersigned, hereby acknowledge that the colon therapist has not and is not prescribing (order for use of medicine) for me at any time, and I the undersigned will not hold the above accountable for such. This therapist is helping me with natural hygiene at my own request.

Signature_____