d'avignon
DIGESTIVE HEALTH CENTRE

Confidential Client Record

Date: _____ Referral source: _____

Name: _____ Date of birth: _____

Address: _____ City: _____ Postal code: _____

Cell: _____ Alternate: _____ Email: _____

Occupation: _____ May we contact you via email? _____

Do you exercise? (type, frequency, duration) _____
Hobbies, interests, recreational activities: _____
How regularly do you engage in recreation? _____
Usual bed time? _____ Usual wake time? _____ How many hours do you sleep per night? _____
Do you wake up feeling rested? _____ Do you take sleeping pills? _____
Do you keep a regular schedule? _____
Do you travel? _____
_____
What is your current level of stress? ☐ minimal ☐ average ☐ considerable
Blood type: Number of mercury tooth fillings:

Which of the following do you eat/drink?

- ☐ red meat
- ☐ poultry
- ☐ fish
- ☐ milk
- ☐ cheese
- ☐ soy/soy products
- ☐ bread
- ☐ vegetable oil
- ☐ margarine
- ☐ butter
- ☐ whole grains (oats, rice, barley, quinoa)
- ☐ legumes (garbanzo/ kidney/black beans)
- ☐ frozen foods
- ☐ canned foods
- ☐ sushi
- ☐ fast foods
- ☐ junk foods
- ☐ fresh fruit
- ☐ fresh vegetables
- ☐ pop
- ☐ coffee
- ☐ tea
- ☐ juice
- ☐ alcohol
- ☐ water

What foods do you avoid?

What foods do you crave?

Favorite snack foods?

How often do you eat out?

Where do you shop for food?

How many meals do you eat each day?

List the members of your household

Do you cook?

Do you smoke?

Do you use laxatives?

Notes:

Medications in past 12 months:	Current nutritional supplements:	Food/environmental allergies/ sensitivities:
Diagnosed medical conditions:	Current health concerns/symptoms:	Past hospitalizations/surgeries:
Have you been on any special diets? Are you concerned about your weight?	Have you ever had a colonoscopy?	What are your reasons for getting colonics?

Circle all that apply:

IBS	Hernia	Appendicitis	Polyps	Bloating	Cramping	Vomiting
Crohn's	Gallstones	Ulcer	Hemorrhoids	Flatulence	Nausea	Constipation
Colitis	Kidney stones	Gout	Anal fissure	Burping	Acid reflux	Diarrhea

How have your bowel movements been over the last six months? Circle all that apply.

Frequency	**Consistency**	**Contents**	**Length**	**Width**	**Texture**	**Colour**	**Time**
Daily	Hard, dry	Mucus	Chunks/ balls	Feels too big to pass	Lumps pressed together	Light to dark brown	5 min. or less (pass easily)
Every 2 days	Firm	Fat floating	2-3"	1-2"	Odd shapes and sizes	Orange/ yellow brown	5 – 15 min. (strain)
Weekly	Soft	Blood	3-6"	½ - 1"	Breaks up in water	Grey	15+ min. (strain)
Less than once a week	Loose • watery • fatty blob	Speckles/ bits of food	6" or more	Pencil-thin	Smooth, well formed	Black	

Notes:

I hereby acknowledge that the personnel at DDHC are not prescribing (ordering for use as medicine) for me at any time, and I will not hold them accountable for such. The services I receive at DDHC are initiated by me for personal reasons.

Signature: **Date:**

Thank you