

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: _____

<p>Which of the following do you eat/drink?</p> <table border="0"> <tr> <td><input type="checkbox"/> red meat</td> <td><input type="checkbox"/> frozen foods</td> </tr> <tr> <td><input type="checkbox"/> poultry</td> <td><input type="checkbox"/> canned foods</td> </tr> <tr> <td><input type="checkbox"/> fish</td> <td><input type="checkbox"/> sushi</td> </tr> <tr> <td><input type="checkbox"/> milk</td> <td><input type="checkbox"/> fast foods</td> </tr> <tr> <td><input type="checkbox"/> cheese</td> <td><input type="checkbox"/> junk foods</td> </tr> <tr> <td><input type="checkbox"/> soy/soy products</td> <td><input type="checkbox"/> fresh fruit</td> </tr> <tr> <td><input type="checkbox"/> bread</td> <td><input type="checkbox"/> fresh vegetables</td> </tr> <tr> <td><input type="checkbox"/> vegetable oil</td> <td><input type="checkbox"/> pop</td> </tr> <tr> <td><input type="checkbox"/> margarine</td> <td><input type="checkbox"/> coffee</td> </tr> <tr> <td><input type="checkbox"/> butter</td> <td><input type="checkbox"/> tea</td> </tr> <tr> <td><input type="checkbox"/> whole grains (oats, rice, barley, quinoa)</td> <td><input type="checkbox"/> juice</td> </tr> <tr> <td><input type="checkbox"/> legumes (garbanzo/kidney/black beans)</td> <td><input type="checkbox"/> alcohol</td> </tr> <tr> <td></td> <td><input type="checkbox"/> water</td> </tr> </table>	<input type="checkbox"/> red meat	<input type="checkbox"/> frozen foods	<input type="checkbox"/> poultry	<input type="checkbox"/> canned foods	<input type="checkbox"/> fish	<input type="checkbox"/> sushi	<input type="checkbox"/> milk	<input type="checkbox"/> fast foods	<input type="checkbox"/> cheese	<input type="checkbox"/> junk foods	<input type="checkbox"/> soy/soy products	<input type="checkbox"/> fresh fruit	<input type="checkbox"/> bread	<input type="checkbox"/> fresh vegetables	<input type="checkbox"/> vegetable oil	<input type="checkbox"/> pop	<input type="checkbox"/> margarine	<input type="checkbox"/> coffee	<input type="checkbox"/> butter	<input type="checkbox"/> tea	<input type="checkbox"/> whole grains (oats, rice, barley, quinoa)	<input type="checkbox"/> juice	<input type="checkbox"/> legumes (garbanzo/kidney/black beans)	<input type="checkbox"/> alcohol		<input type="checkbox"/> water	What foods do you avoid?
	<input type="checkbox"/> red meat	<input type="checkbox"/> frozen foods																									
	<input type="checkbox"/> poultry	<input type="checkbox"/> canned foods																									
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	<input type="checkbox"/> water																										
	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:
Are you concerned about your weight?	Have you been on any special diets?	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

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 <ul style="list-style-type: none"> • 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