Mt Rainier Clinic PLLC

Colon Therapy Questionnaire

Personal

Name: ____________________________________ Date of Birth :________________________
Have you had Colonics Before? _______________ How Many? ____________ Last Date: _______________
Other Cleansing Experiences include:
____

Diet and Life Style

Frequency of consumption:
Fish/Poultry: __________ Red Meat: _________ Dairy: __________ Eggs: _______
Flour/Bread: __________ Caffeine: __________ Sugar: ___________ Salt: ________
Artificial Sweeteners: ____________ Soft drinks: ______________ Alcohol: _____________ Smoke: _______

Health Conditions

Do You have problems with (please circle): constipation diarrhea, abdominal pain, hemorrhoids, gas
How often do you have bowl movements? ______________ Any other colon problems?
____
Have you taken antibiotics in the past? _______ Chemical laxatives? ________ Birth Control?
____
Food allergy or restrictions:
____
Diagnosed health conditions: _________________ Bleeding disorder? ______ Heart condition:
____
Do you have an infectious disease? ____________ If yes, please specify: ________________________________

Check All That Apply

__ Abdominal surgery
__ Acute abdominal pain
__ Cancer of colon or GI tract
__ Carcinoma of rectum
__ Cirrhosis
__ Congestive heart failure
__ Diverticulitis
__ Epilepsy or psychoses
__ Fissures or fistula
__ General debilitation
__ Heart attack
__ History of seizure
__ Intestinal perforation
__ Pregnancy
__ Renal insufficiency
__ Recent colon or rectal surgery
__ Recent history of GI bleeding
__ Severe hemorrhoids
__ Uncontrolled hypertension
__ Vascular aneurysm

Patient Signature____ Date ___________

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