Inner Care WELLNESS

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Referring doctor:	**Date of visit:**

PERSONAL HEALTH HISTORY

Infections: ☐ Stomach/Intestinal ☐ Cold/Flu ☐ Bacterial/Viral ☐ Fungal ☐ Parasitic ☐ Skin/Rashes ☐ Lung/Respiratory	
Major Illness(es):	☐ Recent Blood/Lab Work

List any medical problems that other doctors have diagnosed

Major Surgeries and Hospitalizations

Year	Reason	Outcome (medication, symptom)

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies

Name the Drug, Food, or Allergen	Reaction You Had

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HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., heart rate up 3x/week for 30 min. or less)					
	☐ Regular vigorous exercise (i.e., heart rate up 4x/week for 30 min.)					
Diet	Are you on a special diet or meal plan?				☐ Yes	☐ No
	If yes, is this a physician prescribed diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank sugar intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soda		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ # of years	☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
Other	Are you seeking help today with any habits listed on this page?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Child's name**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling's name	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Pet(s)**	☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	

MENTAL HEALTH & STRESS

Do you have major stress in your life (e.g., home, work, other)?	☐ Yes	☐ No
Do you feel depressed or draggy?	☐ Yes	☐ No
Do you panic or get anxious when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you take medication to support emotional health?	☐ Yes	☐ No
Do you have trouble sleeping? If no, do you take a sleep aid?	☐ Yes	☐ No

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WOMEN ONLY

Irregular periods?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No

MEN ONLY

Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Date of last prostate exam?	☐ Yes	☐ No

DIGESTIVE SYMPTOMS

Check if you have had any symptoms in the following areas. Circle if the symptom is current.

☐ Constipation	☐ Difficult bowel movements	☐ Repeated antibiotic exposure
☐ Diarrhea	☐ Pain in low back	☐ Energy level 1-10 _____
☐ Blood in stool or rectal area	☐ Indigestion after meals	☐ Often feeling hot or cold
☐ Body odor, bad breath, or foul smelling gas	☐ Shaky before eating	☐ Headaches
☐ Pressure in pit of stomach	☐ Acid Reflux, Heartburn, GERD	☐ Bruise easily
☐ Gallbladder problems	☐ Laxative or softener use	☐ Eyes swollen, puffy, or dark circles
☐ Habit of overeating	☐ Burning sensation in stomach	☐ Skin Itching, Peeling, or Cracking
☐ Emotional eating	☐ Burning or itching anus	☐ Skin Acne, Pimples, Blemishes, or Rashes
☐ Habit of under-chewing	☐ "Nervous" or upset stomach	☐ Nails and Hair Dry, Thin, Brittle
☐ Difficulty swallowing	☐ Stool is very dark	☐ Eczema or Psoriasis
☐ Digestion is difficult	☐ Feeling of incomplete evacuation	☐ Susceptible to colds and/or flu
☐ Bitter taste in mouth	☐ Weight gain	☐ Poor sleep
☐ Irritability around meals	☐ Nausea and/or vomiting	☐ Achy joint(s)
☐ White-coated tongue	☐ Gag easily	☐ High blood pressure (controlled)
☐ Sugar or alcohol cravings	☐ Gall Stones or Kidney Stones	☐ Other symptom(s), please list:
☐ Caffeine or nicotine cravings	☐ Diverticulitis or Diverticulosis	☐
☐ Salt cravings	☐ Hemorrhoids	☐
☐ Always hungry	☐ Thyroid Problems	☐
☐ High dairy consumption	☐ Liver disease	☐
☐ Abdominal bloating	☐ Anorexia or Bulimia	☐
☐ Tension under ribcage	☐ Preoccupied with food or exercise	☐
☐ Dairy sensitivity	☐ Gas feels "trapped"	☐
☐ Abdominal pain or cramping	☐ Hearing abdominal noises	☐
☐ Belching or Flatulence, excessive	☐ Low blood sugar	☐
☐ Reduced or loss of appetite	☐ Mucous in stool	☐
☐ Ulcers	☐ Very dark or black stool	☐

What brings you to Inner Care? Please use the space below to describe your current symptoms.

Please read the following sections, and ask your therapist if it is unclear. Initial, sign, and date.

FINANCIAL RESPONSIBILITY

I clearly understand and agree that all services rendered are charged directly to me, and I am personally responsible for payment. I also understand that if I am late for an appointment, or suspend or terminate a session early, any fees or professional services will not be refunded. **INITIALS**_____

CANCELLATION POLICY

Unless canceled at least 48 hours in advance, it is the policy of Inner Care to charge at the rate of the appointment -- unless the opening is filled from the waiting list. **INITIALS**_____

CONTRAINDICATIONS

The following is a list of contraindications for Colon Hydrotherapy. Please review these carefully.

Abdominal Hernia, Abdominal Surgery (within 12 weeks), Acute Liver Failure, Aneurysm, Colon Cancer, Congestive Heart Failure, Crohn's Disease, Colitis, Dialysis, Fissures/Fistulas, Hemorrhaging, Intestinal Perforations, Pregnancy 3rd Trimester, Rectal or Colon Surgery (within 12 weeks), Renal Insufficiencies **By initialing here, I agree I do not have the above or I have a prescription from my healthcare provider authorizing me to receive Colon Hydrotherapy. **INITIALS**_____

INFORMED CONSENT & DISCLAIMER

I hereby approve Kandyl Crawford, Colon Therapist of Inner Care, to touch me in accordance with the procedure. I acknowledge that Kandyl is a Therapist, not a Medical Doctor, and that she does not diagnose any disease or condition. If any changes in my medications or digestive health occur, I will inform her, at my next appointment. Any information I receive from Kandyl is to be used for educational purposes, in order to assist me in making the best decisions for my health. *Note: The nutritional and health information provided by Kandyl, during any consultation, meeting, newsletter, or handout, is based on personal experience, research, and experiences of clients at Inner Care. This information is to be used for educational purposes. If I choose to use diet and lifestyle changes as a form of treatment for illness or disease without the approval of a medical physician, I am prescribing for myself.* I give consent and agree to accept the terms of this disclaimer concerning my own health.

SIGNATURE_____**DATE**_____