



# Colon Hydrotherapy

Glastonbury Naturopathic Center, 18 School Street, Glastonbury, CT 06033  
Dr. Helene Pulnik, N.D., Medical Director **phone 860.657.4105**

## Client Information Questionnaire

Please help us provide you with the most appropriate and effective service by completing the following questions. All information is kept confidential.

### PERSONAL DATA (please print)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City /State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

E-mail (for newsletters and special offerings) \_\_\_\_\_

Occupation \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Primary physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

### HOW DID YOU FIND US?

- Practitioner (name & specialty) \_\_\_\_\_  Connecticut Holistic Health Association
- Physician (name & specialty) \_\_\_\_\_  Door Opener
- Friend (friend's name) \_\_\_\_\_  Glastonbury Naturopathic Center Advertising
- Yellow Pages/Directories \_\_\_\_\_  Spirit of Change
- Internet search (specify) \_\_\_\_\_  www.cleanmycolon.com

### COLON HEALTH

Is this your first Colon Hydrotherapy session?  Yes  No

If not, where and when was your most recent visit? \_\_\_\_\_

What, if any, is your prior experience with colon cleansing, other than hydrotherapy?

fasting  juicing  herbs  enemas  other \_\_\_\_\_

If you use laxatives and/or stool softeners, how often? \_\_\_\_\_

Are you currently fasting?  Yes  No Are you currently cleansing?  Yes  No

If yes, type of fast or cleanse program: \_\_\_\_\_

My intention for hydrotherapy is: \_\_\_\_\_

Which of the following apply to you? Use "C" for Currently, "P" for Past.

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Abdominal Gas           | <input type="checkbox"/> Colitis              | <input type="checkbox"/> Gallstones               | <input type="checkbox"/> Nausea                    |
| <input type="checkbox"/> Anal discomfort/itching | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Gas after eating         | <input type="checkbox"/> Parasites                 |
| <input type="checkbox"/> Anal /rectal bleeding   | <input type="checkbox"/> Cramping             | <input type="checkbox"/> Gastroparesis            | <input type="checkbox"/> Polyps                    |
| <input type="checkbox"/> Appendicitis            | <input type="checkbox"/> Crohn's              | <input type="checkbox"/> Hemorrhoids              | <input type="checkbox"/> Poor appetite             |
| <input type="checkbox"/> Atonic colon            | <input type="checkbox"/> Diverticulitis/osis  | <input type="checkbox"/> Hernia                   | <input type="checkbox"/> Reduntant/prolapsed colon |
| <input type="checkbox"/> Bad Breath              | <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Hungry all the time      | <input type="checkbox"/> Reflux/heartburn          |
| <input type="checkbox"/> Belching / Bloating     | <input type="checkbox"/> Fatigue after eating | <input type="checkbox"/> Indigestion              | <input type="checkbox"/> Spastic colon             |
| <input type="checkbox"/> Carcinoma               | <input type="checkbox"/> Fissure / Fistula    | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Vomiting                  |
| <input type="checkbox"/> Celiac disease          | <input type="checkbox"/> Food Allergies       | <input type="checkbox"/> Lactose intolerance      | <input type="checkbox"/> Worms in stool            |

Please list any intestinal-related procedures you have had, along with the year it took place:

- barium enema, year \_\_\_\_\_       colonoscopy, year \_\_\_\_\_       sigmoidoscopy, year \_\_\_\_\_  
 surgery, year \_\_\_\_\_       other \_\_\_\_\_, year \_\_\_\_\_

**BOWEL HEALTH**

How many bowel movements do you usually have?      Number Per day \_\_\_\_\_      Number Per week \_\_\_\_\_

Do you strain to have a movement?     Yes     No      Does the movement feel complete?     Yes     No

Please check applicable responses. The stool . . .

- Shows signs of mucus       Shows signs of blood       Has a strong odor

**GENERAL HEALTH**

What is your blood type?     A     AB     B     O

Have you been hospitalized within the past year? \_\_\_\_\_ in the last 5 years? \_\_\_\_\_

Why? \_\_\_\_\_

Which of the following apply to you? Use "C" for Currently, "P" for Past.

- |                                 |                                   |                                 |                                |
|---------------------------------|-----------------------------------|---------------------------------|--------------------------------|
| _____ Allergies                 | _____ Depression                  | _____ Heart condition           | _____ Mental disorder          |
| _____ Anemia                    | _____ Diabetes                    | _____ Heart disease             | _____ Nerve disorder           |
| _____ Anxiety                   | _____ Dizziness                   | _____ High/low blood pressure   | _____ PMS                      |
| _____ Arthritis                 | _____ Eating disorders            | _____ Irregular menstrual cycle | _____ Prostate condition       |
| _____ Asthma                    | _____ Edema                       | _____ Kidney stones             | _____ Renal insufficiency      |
| _____ Auto immune disorder      | _____ Environmental sensitivities | _____ Liver disease             | _____ Sinus condition          |
| _____ Bloodclot/vessel disorder | _____ Epstein-Barr                | _____ Loss of sleep             | _____ Skin condition           |
| _____ Cancer                    | _____ Extreme weight gain/loss    | _____ Low blood sugar           | _____ Spleen/pancreas problems |
| _____ Candida                   | _____ Fainting                    | _____ Low libido                | _____ Sweats                   |
| _____ Chemical toxicity         | _____ Fatigue                     | _____ Lung disorder             | _____ Thyroid problems         |
| _____ Cholesterol high/low      | _____ Fever/chills                | _____ Lupus                     | _____ Toxicity                 |
| _____ Chronic pain              | _____ Fibro/polymialgia           | _____ Lyme disease              | _____ Tumor                    |
| _____ Convulsions               | _____ Fibroid cysts               | _____ Metal poisoning           | _____ Ulcer                    |
| _____ Currently _mnths pregnant | _____ Headaches/migraines         | _____ Menopause                 | _____ Urinary tract infection  |

Have you been recently diagnosed with a major illness? Please describe.

\_\_\_\_\_

Have you recently had chemotherapy? \_\_\_\_\_

**Do you use any of the following?**

- antibiotics \_\_\_\_\_       prescription drugs (please list) \_\_\_\_\_       supplements (please list) \_\_\_\_\_  
 over-the-counter drugs \_\_\_\_\_  
 pacemaker (how long?) \_\_\_\_\_  
 prescribed birth control \_\_\_\_\_  
 recreational drugs \_\_\_\_\_  
 steroids \_\_\_\_\_  
  
 antidepressants (please list): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DIET**

Using the following key, please indicate your dietary usage.

F = Frequent (5-7 times a week)

L = Light (once a week or less)

M = Moderate (2-4 times a week)

N = Never (really, never!)

- |   |   |  |  |   |
|---|---|--|--|---|
| <input type="checkbox"/> Alcohol            | <input type="checkbox"/> Cheese             | <input type="checkbox"/> Fried Foods   | <input type="checkbox"/> Poultry         | <input type="checkbox"/> Soda                 |
| <input type="checkbox"/> Antacids           | <input type="checkbox"/> Chocolate          | <input type="checkbox"/> Fruit         | <input type="checkbox"/> Popcorn         | <input type="checkbox"/> Soy                  |
| <input type="checkbox"/> Aspirin            | <input type="checkbox"/> Dairy              | <input type="checkbox"/> Gum           | <input type="checkbox"/> Processed Foods | <input type="checkbox"/> Sugar                |
| <input type="checkbox"/> Beans              | <input type="checkbox"/> Decaf Coffee / Tea | <input type="checkbox"/> Ice Cream     | <input type="checkbox"/> Protein Shakes  | <input type="checkbox"/> Tobacco/cigarettes   |
| <input type="checkbox"/> Bread              | <input type="checkbox"/> Desserts           | <input type="checkbox"/> Junk Food     | <input type="checkbox"/> Psyllium Fiber  | <input type="checkbox"/> Vegetables           |
| <input type="checkbox"/> Caffeinated Coffee | <input type="checkbox"/> Eggs               | <input type="checkbox"/> Milk          | <input type="checkbox"/> Red Meat        | <input type="checkbox"/> Water                |
| <input type="checkbox"/> Caffeinated Tea    | <input type="checkbox"/> Fatty Foods        | <input type="checkbox"/> Nuts / Seeds  | <input type="checkbox"/> Salads          | <input type="checkbox"/> Wheat/flour products |
| <input type="checkbox"/> Candy              | <input type="checkbox"/> Fish               | <input type="checkbox"/> Organic Foods | <input type="checkbox"/> Salt            | <input type="checkbox"/> Whole Grains         |
| <input type="checkbox"/> Carbonated Water   | <input type="checkbox"/> Flax Fiber         | <input type="checkbox"/> Pasta         | <input type="checkbox"/> Smoothies       | <input type="checkbox"/> Yogurt               |

**BRIEFLY DESCRIBE YOUR TYPICAL DIETARY INTAKE FOR THE FOLLOWING MEALS**

Breakfast \_\_\_\_\_

\_\_\_\_\_

Lunch \_\_\_\_\_

\_\_\_\_\_

Dinner \_\_\_\_\_

\_\_\_\_\_

Snacks / Desserts \_\_\_\_\_

Do you have any food cravings?  No  Yes \_\_\_\_\_

**LIFESTYLE:**

Are you currently under any excessive or unusual mental or physical stress? Please describe briefly:

\_\_\_\_\_

How do you relax? \_\_\_\_\_

Do you exercise?  No  Yes What forms of exercise do you do? \_\_\_\_\_

Do you practice any forms of:  Meditation  Prayer  12 Step-Program  Other \_\_\_\_\_

Are you, or have you been, addicted to:

Alcohol  Coffee  Sugar  Tobacco  Drugs  Prescription drugs  Other \_\_\_\_\_

If there are other areas of your life/lifestyle (such as emotional, mental, or physical trauma) that you feel would be appropriate for us to know in order to better meet your needs, please feel free to comment in the space below.

All information is strictly confidential.

\_\_\_\_\_

\_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_