

**2808 Columbine Pl
Nashville, TN 37204
615-440-9596
615-517-0704**

Please write or print clearly. All of your information will remain confidential.

Personal information

Name: _____ Date: _____

Address: _____

City _____ State: _____ Zip _____

Email: _____

Phone: _____

Age: _____ Birthdate: _____ Sex: _____

Height: _____ Current weight: _____

Weight six months ago: _____ Weight a year ago: _____

Would you like your weight to be different? _____ If so what? _____

Relationship status: _____

Emergency contact info: _____

Children: _____ Pets: _____

Occupation: _____ Hours of work per week: _____

Referred by: _____

Health Information

Have you had colon hydrotherapy before?_____ If yes where? _____

Please state you reason for and expectations for your session? _____

Please list your main health concerns and/or goals? _____

At what point in your life did you feel your best? _____

Do you use any of the following on a daily basis? If yes how often?

Alcohol_____

Tobacco/Vaping products/E cigarettes_____

Coffee/Tea/Soda _____

Please mark any of the following you have/had and give a brief explanation.

Fatigue_____ Headaches_____

Bloating_____ Sugar cravings_____

Constipation Diarrhea/Gas/IBS _____

Alternating periods of constipation and diarrhea _____

Hemorrhoids _____ Rectal bleeding/surgery_____

Low/high blood pressure_____ Cancer_____

Leaky Gut Syndrome _____ Hepatitis_____

Skin issues _____

Poor immunity _____ Stress _____

Autoimmune disease _____

Any pain/stiffness/swelling _____

Allergies or sensitivities? Please explain: _____

How is your sleep? _____ How many hours? _____ Do you wake up
at night? _____ Why? _____

Exercise? _____

Hobbies? _____

How many bowel movements do you have each day? _____

Do you take any prescription/over the counter medications? _____

Do you take any vitamins/herbal supplements? _____

Any holistic therapies that you receive? _____

How frequent do you have a bowel movement? _____

Do you strain? _____ Do you use a prescription/over the counter/herbal laxative? _____

List all surgeries and major illness? _____

Women's Health

Are you pregnant? ____ Are your periods regular? ____ How many days are your period? _____

How frequent? _____ Painful or symptomatic? _____

Please explain? _____

Reached or approaching menopause? _____

Birth control history: _____

Do you experience yeast infections or urinary tract infections? _____

Please explain: _____

Food Information

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What is your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? _____

Do you cook? _____

What percentage of your food is home cooked? _____

Where do you get the rest? _____

The most important thing you should do to improve your health is:

Anything else you want to share? _____

What is your stress level on a scale of 1-5? _____

Any contributing factors increasing your stress? _____

Are you interested in learning more about diet and lifestyle changes? How can I best help you achieve your health goals? _____

Cancellation/Refund Policy

Please note the following policy is in place as a courtesy to the practitioners, as we work by appointment only. More importantly, to other clients who may be on a waiting list and very eager to obtain any availability.

All clients are required to give us at least 48 hours notice prior to any appointment cancellation. Any appointments that are canceled with less than 48 hour notice will be charged a cancellation fee of \$30. Clients that do not show up for their scheduled appointments will be charged the full fee of the scheduled service or have one session deducted from their package.

If the client is more than 15 minutes late to an appointment, they will need to reschedule and will be charged a fee of \$30.