



PERSONAL HISTORY

NAME _____ DATE _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 HOME PHONE _____ WORK PHONE _____
 BIRTHDATE _____ AGE _____ SEX (M) (F) E-MAIL _____
 MARITAL STATUS (S) (M) (D) (W) SPOUSE _____ # OF CHILDREN _____
 OCCUPATION _____ REFERRED BY _____

Please UNDERLINE all of the following symptoms which you have now or have had previously. Be as thorough as possible.
 YOUR HEALTH HISTORY IS CONFIDENTIAL!

GENERAL SYMPTOMS

- Headache
- Fever
- Chills
- Sweats
- Fainting
- Allergy

- Dizziness
- Convulsions
- Loss of sleep
- Fatigue
- Nervousness/Depression

- Loss of weight
- Overweight
- Numbness in: _____

EYES, EARS, NOSE & THROAT

- Failing vision
- Near sightedness
- Far sightedness
- Crossed eyes
- Eye pain

- Deafness
- Earache
- Ear noises
- Ear discharge
- Nose bleeds
- Nasal obstruction
- Nasal drainage

- Sore throat
- Swollen lymph glands
- Enlarged thyroid
- Hoarseness

- Colds
- Sinus infection
- Hay fever
- Asthma

- Dental decay
- Gum trouble

SKIN

- Skin eruptions
- Itching
- Bruises easily
- Dryness
- Boils
- Varicose veins
- Sensitive skin
- Hives or allergy

RESPIRATORY

- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Difficult breathing

CARDIO-VASCULAR

- Rapid beating heart
- Slow beating heart
- High blood pressure
- Low blood pressure
- Pain over heart
- Heart attack

- Swelling of ankles
- Poor circulation

MUSCLE, BONE, JOINT

- Stiff neck
- Backache
- Swollen joints
- Tremors

- Painful tailbone
- Foot or ankle trouble
- Pain in: shoulders, arms, elbows, hands, hips, legs, knees, feet, other?

- Hernia
- Spinal curvature
- Faulty posture

GENITO-URINARY

- Frequent urination
- Painful urination
- Blood in urine
- Pus in urine
- Kidney trouble
- Incontinence
- Prostate trouble

GASTRO-INTESTINAL

- Poor appetite
- Excessive hunger
- Difficult digestion
- Belching or gas
- Distention of abdomen
- Nausea
- Vomiting
- Vomiting of blood
- Pain over stomach
- Pain over lower abdomen

- Constipation
- Diarrhea
- Colon trouble
- Hemorrhoids or Piles
- Rectal bleeding
- Bloody stool
- Intestinal worms

FOR WOMEN ONLY

- Painful menstrual periods
- Excessive menstrual flow
- Hot flashes
- Irregular cycles
- Cramps or backache
- Miscarriage
- Vaginal discharge
- Lumps in breast
- Menopausal symptoms

(Please continue on other side)

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

- | | | | | |
|------------------|----------------|-----------------|--------------------|--------------------|
| Alcoholism | Diabetes | Goiter | Multiple Sclerosis | Stroke |
| Anemia | Diphtheria | Gout | Nervous Breakdown | Smallpox |
| Appendicitis | | Heart Problem | Other: _____ | Tuberculosis |
| Arteriosclerosis | Eczema | | Pleurisy | Typhoid Fever |
| Arthritis | Emphysema | Malaria | Pneumonia | |
| Cancer | Epilepsy | Measles | Polio | Ulcers |
| Chicken Pox | Fever Blisters | Mental Disorder | Rheumatic Fever | Venereal Infection |
| Colitis | Flu | Mumps | Scarlet Fever | Whooping Cough |

HAVE YOU EVER: (Please describe the what and when of any situation below)

Had any unusual accidents or falls? _____

Had any bone fractures? _____

Been knocked unconscious? _____

Had any surgical operations? _____

HABITS:

SLEEP - Hours daily? _____ Is it enough? _____

EXERCISE - Daily? _____ Is it enough? _____

FRESH AIR - Daily? _____ Is it enough? _____

WATER - Daily? _____ Is it enough? _____

FOOD - Too much or too little? _____ Use proper food combining? _____

BOWEL MOVEMENT - Daily? _____ When was last BM? _____

POSITIVE ATTITUDE - Consistant? _____

EMOTIONS - Do you feel they are in balance? _____

DO YOU USE ANY OF THE FOLLOWING ON A DAILY BASIS?

Alcohol (Y) (N)

Tobacco (Y) (N)

Coffee (Y) (N)

Tea (Y) (N)

Supplements:

Vitamins _____

Minerals _____

Herbs _____

Drugs and medications - What kind and what for? _____

MOST RECENT MEDICAL SERVICE/HOSPITALIZATION: For what, where & when? _____

HAVE YOU HAD PROFESSIONAL COLON HYGIENE/LOWER BOWEL EVACUATION SESSIONS BEFORE? (Y) (N)

Where and when? _____

YOUR PRIMARY REASON FOR USING THIS SERVICE: _____

YOUR #1 HEALTH GOAL OR CONCERN AT THIS TIME: _____

Client Signature

Date