A Start to a Better Health
Colonics Plus

Client Intake Form

Name	_____
Date of Birth	_____
Age	_____
Phone	_____
Email	_____
Address	_____
City/State/ZIP	_____
Height	_____
Weight	_____
Referred By	_____

Health History

Please check any that apply:

Arthritis, Asthma, Allergies, Backache, Bad Breath, Cancer (Type:_____), Candida, Chronic Fatigue, Colitis, Constipation, Diabetes, Diarrhea, Diverticulitis, Eye Conditions, Foot Pain, Gastritis, Gallbladder Issues, Headaches, Heart Conditions, Hemorrhoids, Hernia, Indigestion, Kidney Issues, Prostate Issues, Skin Disorders, Uterus Issues, Miscarriage, Chemotherapy, Radiation.

Surgeries: _____

Current Medications: _____

Doctor's Care (Explain): _____

Previous Colonics (Date/Results): _____

Diet: _____

Exercise (Frequency/Type): _____

Blood Pressure / Pulse / Cholesterol: _____

Signature: _____ Date: _____