TENNESSEE COLONICS

Personal History Form

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Cell Phone_____E-Mail Address_____

Birthdate_____ Age_____ Sex_____

Marital Status_____ Spouse_____ # of Children_____

Occupation_____ Referred by_____

Please circle all of the following symptoms which you now have 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
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 Tonsils
Enlarged Lymph Glands
Enlarged Thyroid
Hoarseness
Colds
Sinus Infection
Hay Fever
Asthma
Dental Decay
Gum Trouble

Skin
Skin Eruptions
Itching
Bruises Easily
Dryness
Boils
Varicose Vein
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
Faulty Posture

Genito-Urinary
Frequent Urination
Painful Urination
Blood in Urine
Pus in Urine
Kidney Trouble
Inability to Control Urine
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 Abs
Constipation
Diarrhea
Colon Trouble
Hemorrhoids or Piles
Rectal Bleeding
Bloody Stools
Intestinal Worms
Liver Trouble
Gall Bladder Trouble
Jaundice

For Women Only
Painful Menstrual Periods
Excessive Menstrual Flow
Hot Flashes
Irregular Cycle
Cramps or Backache
Miscarriage
Vaginal Discharge
Lumps in Breast
Menopausal Symptoms

Recent Symptoms?

Circle Any of the Following Conditions You Have Had:

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

Have you ever: Please describe the what and when of any situation below:

Had any unusual accidents of falls? _____
_____

Had any bone fractures? _____
_____

Been knocked unconscious? _____
_____

Had any surgical operations? _____

Habits:

Sleep- Hours Daily? _____ Is it enough?_____
Exercise- Hours Daily? _____ Is it enough?_____
Fresh Air- Hours Daily? _____ Is it enough?_____
Water- Hours Daily? _____ Is it enough?_____
Food- Too much of little?_____ Use proper food combining?_____
Positive Attitude- Consistent? _____
Emotions- Do you feel they are in balance?_____

Do you use any of the following on a daily basis?

Alcohol
Coffee
Tea
Tobacco
Supplements:
- Vitamins
- Minerals
- Herbs

Drugs/Medications- What kind and what for? _____
Other:_____

Most recent medical service/hospitalization? For what, where and when? _____
_____

Have you ever had professional colon hygiene/lower bowel evacuation sessions before? No_____ Yes _____
Where and when?_____

Your primary reason for using this service?_____
_____

Your #1 health goal or concern at this time? _____
_____

_____
Client Signature