EXPEDITED COLON THERAPY SCREENING QUESTIONNAIRE

Name: _____ Today's Date: _____ Location (circle) Raleigh Wilmington
Phone: _____ Email: _____ Send to tachelle@carolinacenter.com

What condition do you hope to address by undergoing colon hydrotherapy?

_____

_____

_____

Is this a condition for which you are currently under medical care? (circle) Yes No If yes, explain further: _____

_____

Do you have any of the following digestive disorders:

- ☐ Repeated stomach pain
- ☐ Heartburn
- ☐ Indigestion
- ☐ Gum problems
- ☐ Belching
- ☐ Change in appetite
- ☐ Nausea or vomiting
- ☐ Difficulty swallowing
- ☐ Vomiting blood
- ☐ Constipation
- ☐ Black stools
- ☐ Blood in stools
- ☐ Diarrhea more than 3 days
- ☐ History of bowel surgery
- ☐ History of inflammatory bowel disease
- ☐ Rectocele

Do you have any of the following:

- Any symptoms or history of colon or rectal disorders? ___No ___ Yes
  If yes, please explain: _____
- Any symptoms or history of upper GI disorders (reflux, gastritis, etc.)? ___No ___ Yes
  If yes, please explain: _____
- Any family history of colon polyps or colon cancer? ___No ___ Yes
  If yes, which family members and age of diagnosis: _____
- Any cardiopulmonary disease (heart disease, hypertension, etc.)? ___No ___ Yes
  If yes, please explain: _____
- Any neurological disease? ___No ___ Yes
  If yes, please explain: _____
- Any anti-coagulation medications? ___No ___ Yes
  If yes, for what condition: _____

Patient Signature: _____ Date: _____

STAFF USE ONLY:

Reviewer Notes:

_____

_____

Reviewer Signature: _____ Title: _____ Date: _____