

Healthy Directions Center Health History Questionnaire

Suppression and Obstruction to Cure Index

Number of Organs removed (Including teeth)		Personal Stress 0-10(10=Maximum)	
Number of Synthetic Drugs Used (Includes prescription medications)		Number of Sugar Type Products or Processed Foods per Day	
Amount of Smoking per Day (Number of Cigarettes, Cigars, etc.)		Number of Exercise sessions per week	
Number of Steroid Type Drugs Used in the Last Year		Number of Alcoholic Drinks per Day (Not over 3/day for men; 2day for	
Number of Mercury Amalgam Fillings Current or Present		Number of Cups of Coffee or Tea per Day	
Number of Street Drugs use Monthly (Includes Recreational Chemicals)		Number of Extreme Toxic Exposures Per Year	
Number of known Allergies (Foods, Skin and Inhalants)		Number of Major Injuries in the Past (Physical and Emotional Traumas)	
Number of unresolved Mental Factors (Stuck or unresolved Emotions)		Number of Major Infections in the Past or Present	
I am responsible for My Body 0 = Minimum 10 = Maximum		Number of Glasses of Water or Natural Fruit Juice Per Day	
Amount of fat in Diet, as Percent/10 Including Processed Foods		How Many Kilos Overweight (2.2 lb = 1 kilogram) as Seen by Client	

Orthopedic History: (Please check all Past injured Regions including surgeries, type & date. Please circle R= Right L = Left.)

<input type="checkbox"/> Head	<input type="checkbox"/> Thoracic Spine
<input type="checkbox"/> Neck (Cervical)	<input type="checkbox"/> Lumbar Spine
<input type="checkbox"/> TMJ	<input type="checkbox"/> Hips R/L
<input type="checkbox"/> Shoulders R/L	<input type="checkbox"/> Pelvis R/L
<input type="checkbox"/> Elbows R/L	<input type="checkbox"/> Knees R/L
<input type="checkbox"/> Hands R/L	<input type="checkbox"/> Ankles R/L
<input type="checkbox"/> Wrists R/L	<input type="checkbox"/> Feet R/L
<input type="checkbox"/> Other	

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Health History Questionnaire

Colon Health History: Do you suffer from?

<input type="checkbox"/> Irritable Bowel Movement	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Yeast Syndrome
<input type="checkbox"/> Constipation	<input type="checkbox"/> Parasites
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Colitis
<input type="checkbox"/> Spastic Colon	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Hernia	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Allergies	<input type="checkbox"/> Abdominal Gas
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bad Breath/Halitosis
<input type="checkbox"/> Thyroid	

Skin Problems:

<input type="checkbox"/> Eczema	<input type="checkbox"/> Acne
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Do you have your...?

<input type="checkbox"/> Tonsils	<input type="checkbox"/> Adenoids
<input type="checkbox"/> Appendix	

Are you a ...?

<input type="checkbox"/> Vegetarian	<input type="checkbox"/> Meat Eater
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If you do eat meat, how often do you eat the following foods?

Red Meat: _____times per	Turkey: _____times per
Poultry: _____times per week.	Seafood: _____times per

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Contra-indications for Colon Hydrotherapy

Please check all that apply:

<input type="checkbox"/> Cirrhosis of Liver	<input type="checkbox"/> Recent Colon or Rectal Surgery
<input type="checkbox"/> Aneurysms - Blood Clots	<input type="checkbox"/> Colon Disease IBS
<input type="checkbox"/> Gastrointestinal Hemorrhage	<input type="checkbox"/> Carcinoma of the Colon
<input type="checkbox"/> Fissures	<input type="checkbox"/> Abdominal Hernia
<input type="checkbox"/> Fistulas	<input type="checkbox"/> Uncontrolled Hypertension
<input type="checkbox"/> Inflamed Hernia	<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Severe Hemorrhoids - Bleeding
<input type="checkbox"/> Renal Insufficiency	
<input type="checkbox"/> Crohn's Disease	
<input type="checkbox"/> Pregnancy	
<input type="checkbox"/> Moderate Abdominal Hemorrhage	

Bowel Habits

Bowel Movements (number per day)					
1 Never	2 Rarely	3 Sometimes	4 Often	5 Always	
Fowl smelling feces					
Straining at Defecation					
Feeling of Incomplete Defecation					
Lumpy or Hard Stool					
Use of Laxatives					