



Body Balancing Center, LLC.
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Health History

Name: _____ Date: _____

Please review the chart below. Check any and all conditions that pertain to you. Past or Present.

Alcoholism		Heart Problems		Skin Problems	
Arthritis		High Blood Pressure		Spinal Injury	
Blood Clots		Immunosuppression Disease		Tuberculosis	
Bursitis		Infectious Disease		Tumors	
Cancer (all forms)		Joint Pain		Ulcers	
Circulatory Problems		Migraine Headaches		Varicose Veins	
Diabetes (Type I & II)		Muscle Aches		Recent Accidents (Motor Vehicle or Other)	
Digestive Problems		Rapid Weight Gain / Loss		Recent Surgery (Any Kind Including Cosmetic)	
Drug Addiction		Respiratory Problems		Are You Pregnant?	
Epilepsy		Recurrent Infections		Do You Wear Contact Lenses?	
Headaches		Sinus Problems		Do You Smoke?	

1. Why have you chosen to have a Colon Hydrotherapy Session?: _____

2. How frequently do you have a Bowel Movement?: _____

3. Are you currently under a Doctor's Care? (please give name & explanation): _____

4. Please list any medications you are or have been taking _____

5. Please list any supplements you are or have been taking: _____

6. Please list any allergies to foods or medications or other: _____

7. Please list any other pertinent health history you think would be helpful for us to know: _____