



DATE _____

ELIMINATION ASSESSMENT

Dear Patient,

Our ability to draw effective conclusion about your present state of health and how to improve it, depends to a significant extent on your ability to respond thoughtfully and accurately to both these written questionnaires and those posed by the doctor during your consultations. The doctor is the only person who will review these forms and your confidentiality will be maintained. Your careful consideration of each of the following questions will enhance the doctor's efficiency and will provide for more effective use of your consultation time. There are usually a few questions, which you will not know the answers to, simply leave these blank for the time being and proceed from there. Thank you in advance for your time. We look forward to working together to achieve your health goals.

Name: _____ Date of Birth _____

Address: _____ Occupation: _____

City: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Email: _____

Height _____ Weight _____

Who referred you to this clinic? _____

Colon Bowels:

1. My Bowels move: _____ x daily; _____ x week (on average)

2. Laxative use: _____ x daily; _____ x weekly; _____ x monthly; _____ never

Answer codes for the below: 1 never 2 infrequent 3 frequently 4 constantly

3. My stools are: _____ Large (3 fingers wide and 6" plus in length)
_____ Soft and well formed (smooth textured)
_____ Medium 2 fingers wide and 4-6 plus in length and well formed
_____ Thin, long or narrow stools
_____ Often float
_____ Small and hard
_____ Large and hard
_____ Difficult to pass
_____ Loose, but not watery
_____ Diarrhea
_____ Alternates between hard (constipated) and loose and watery (Diarrhea-like)

Stool odor: _____ Usually offensive
_____ Offensive occasionally
_____ Little odor usually

Stool color is: _____ Medium brown, consistently
_____ Dark brown, consistently
_____ Very dark, or black
_____ Yellow, light brown or clay colored
_____ Greenish color
_____ Greasy, shiny appearance
_____ Blood is visible in them
_____ Have mucus in them
_____ Varies a lot

Intestinal gas: _____ Daily
_____ Occasionally
_____ Excessive
_____ Present with pain
_____ Foul smelling
_____ Little odor

4. Do you have trouble initiating your bowel movement, yet the stool is not too large?
Or too hard?
5. Does abdominal discomfort or cramping ever accompany bowel movements?(Y/N)
How often _____
6. Have you ever been diagnosed as having a stomach, liver, gallbladder, pancreas, intestinal or bowel disorder
or disease? (Y/N) If yes please explain
7. Have you had or do you have hemorrhoids or varicose veins? Explain
8. Do you make a conscious effort to eat a high fiber diet? (Y/N) what do you eat?
9. Do you pay attention when nature calls? (Y/N)

Kidney/ Bladder

Answer codes

Y=Yes

N=No

AT= at times

10. Do you use bottled or purified water? (Y/N)
11. Do you drink tap water? Well Or Municipal
12. Do you make a conscious effort to drink 6-8 glasses of water daily? (Y/N)
13. Do you feel satisfied that your bladder is completely empty after urinating? (Y/N)
14. Do you have any burning or irritation during or after urination? (Y/N)
15. Do you have difficulty starting or stopping when urinating? (Y/N)
16. Do you have to get up in the middle of the night to urinate? (Y/N)
How often? _____X night; _____x a week
17. Does the urine have a strong odor to it? (Y/N) Is it usually: Clear _____
Cloudy _____ Bright Yellow _____ Dark Yellow _____ Orange _____

18. At times it has been
Cloudy_____ Orange_____ Red_____ Greenish_____ Brownish_____

19. Please list the number and nature of the beverages you drink daily and regularly.

20. Do you get recurrent bladder infections? (Y/N)

21. Do you get unexplained deep lower back pains just below your ribs? (Y/N)