# Elimination Assessment

Name: _____

Address: _____

**For Office Use**
**Date Sent:** _____
**Date Rec'd:** _____

City: _____ Postal Code: _____

Home Phone: _____ Bus. Phone: _____

_____ Date of Birth: (dd) (mm) (yy) Age: _____

Height: _____ Weight: _____ Occupation: _____

Who referred you to this clinic?

**Colon / Bowels:**

1. My bowels move: _____ x day; _____x week (on the average).

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

*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 texture)
   _____ 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 odour:
_____ Offensive usually
_____ Offensive occasionally
_____ Little odour usually

Stool colour is:
_____ Medium brown, consistently
_____ Dark brown, consistently
_____ Very dark or black
_____ Yellow, light brown or clay coloured
_____ Greenish colour
_____ 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 odour

4. Do you have trouble initiating your bowel movement, yet the stool is not too large or too hard? (Y/N) _____

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 fibre diet? (Y/N) _____ What do you eat?

9. Do you usually pay attention when nature calls? (Y/N) _____

**Kidney / Bladder:**

*Answer codes:* Y = Yes N = No A.T. = At Times

10. Do you use bottled or purified water? (Y/N) _____

11. Do you drink tap water? Well water or Municipal, please underline which one.

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 get up in the middle of the night to urinate? (Y/N) _____
How often? _____ x night; _____x week.

17. Does your urine have a strong odour 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) ____

**Exercise:**

22. Do you exercise regularly? (Y/N) _____ ; _____ x daily; _____ x weekly; _____ x monthly.

23. Please indicate the nature of the exercise and also the number of minutes per session.

24. Do you monitor your pulse while exercising. (Y/N) _____
What is your resting pulse rate? _____ beats per minute.

25. Do you perspire with your exercise? lightly _____; moderately _____; heavily _____.

26. Do you perspire other than when exercising? (Y/N) _____ When?

27. Do you have difficulty perspiring? (Y/N) _____

28. Does your perspiration smell strong? (Y/N) _____
Does it smell like urine? (Y/N) _____

29. Do you get short of breath with even slight exertion? (Y/N) _____

30. What is your basal temperature? (See "axillary temperature test"). _____

31. Do you take regular saunas, steam baths or do cold friction rubs? (Y/N) _____

**Occupational / Household:**

32. What is your occupation?
Please describe the work?

33. Do you work in an office building? (Y/N) _____
How many hours per week? _____
Do the windows open? (Y/N) _____

34. Do you have specialized air filtration at your work place? (Y/N) _____
What type?

35. Do you work in the presence of toxic fumes, or chemicals? (Y/N) _____
Have you ever? (Y/N) _____
Please provide details?

36. Do you smoke? (Y/N) _____
How much do you smoke?

37. Are you exposed to second hand smoke? (Y/N) _____

38. Do you drink alcohol? (Y/N) _____
What type do you drink?

39. How often do you drink alcohol? daily _____; weekly _____; monthly _____.

40. Do you use *any* type of drug (prescription or otherwise)? (Y/N) _____
What type/types?

41. How often, what dosage and for what symptom?

42. Do any of your hobbies involve toxic materials? (Y/N) _____
If so, what kind (paints, plastics, gases, etc.)?

43. Do you have *specialized* air filtration at home? (Y/N) _____
What type?

44. Do you live in a city? (Y/N) _____
How much time do you spend outside per day? _____ Per week? _____

45. Do you wear sunglasses, contact lenses or glasses when outside (underline which one)?

46. Do you have any respiratory disorders, ie. Sinusitis, Asthma, Emphysema, Bronchitis, etc.?
(Y/N) _____ Please explain.

47. Do you have house pets? (Y/N) _____
What type?

**Detoxification:**

48. Have you ever conducted a detoxification programme supervised by a qualified health professional? (Y/N) _____ Please explain.

49. Do you fast? (Y/N) _____
How often and for how long?

50. Are you on a special diet? (Y/N) _____
Please explain.

51. If you avoid any foods or follow a special dietary programme, please explain.

52. On the *average* night, what time do you go to bed? _____
What time do you usually arise? _____
How many hours do you *sleep* on the average night? _____

53. Do you feel well rested on awaking in the morning (ie. ready to arise and get at things)? (Y/N) _____

54. Do you nap or rest horizontally through the day? (Y/N) _____
If yes, for how long on the average? _____

55. On a scale of 1-10, how do you rate the *quality* of your sleep (1 being lousy and 10 being perfectly restful)? _____

**Note:**

This questionnaire is strictly confidential between you and the Doctor. Your accurate responses are vital to effective health care at this office. Please go back over your responses and consider their accuracy. *Thank-you!*

**Signature:** _____

**Date:** _____