

Colon Function

Name: _____ Date: _____

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|-----|---|---|---|---|---|
| 1. | Anal itching | 1 | 2 | 3 | 4 |
| 2. | Hard, dry or small stool | 1 | 2 | 3 | 4 |
| 3. | Extremely narrow and / or thin stool | 1 | 2 | 3 | 4 |
| 4. | Stools have corners or edges are flat or ribbon shaped | 1 | 2 | 3 | 4 |
| 5. | Stools are not well formed (loose watery stools) | 1 | 2 | 3 | 4 |
| 6. | Blood in stool | 1 | 2 | 3 | 4 |
| 7. | Mucous and / or pus in stool | 1 | 2 | 3 | 4 |
| 8. | Excessive foul smelling lower bowel gas | 1 | 2 | 3 | 4 |
| 9. | Bad breath and/or strong body odors | 1 | 2 | 3 | 4 |
| 10. | Lower abdominal pain, tenderness, cramping and / or spasms | 1 | 2 | 3 | 4 |
| 11. | Lower abdominal pain relieved by passing stool or gas | 1 | 2 | 3 | 4 |
| 12. | Raw fruits and/or vegetables causes abdominal bloating, pain, cramps and/or gas | 1 | 2 | 3 | 4 |
| 13. | Painful, difficult and/or straining during bowel movements | 1 | 2 | 3 | 4 |
| 14. | Less than 1 bowel movement per day | 1 | 2 | 3 | 4 |
| 15. | More than 3 bowel movements daily | 1 | 2 | 3 | 4 |
| 16. | An almost continual need to have a bowel movement | 1 | 2 | 3 | 4 |
| 17. | No urge to have a bowel movement | 1 | 2 | 3 | 4 |
| 18. | Feel that bowels do not completely empty | 1 | 2 | 3 | 4 |
| 19. | Alternating diarrhea and constipation | 1 | 2 | 3 | 4 |
| 20. | Bright red blood following bowel movement | 1 | 2 | 3 | 4 |
| 21. | Rectal pain and/or cramps | 1 | 2 | 3 | 4 |
| 22. | Emotional stress causes abdominal bloating, pain, cramps and / or gas | 1 | 2 | 3 | 4 |
| 23. | Irritable and/or moody | 1 | 2 | 3 | 4 |
| 24. | Anxiety and/or depression | 1 | 2 | 3 | 4 |
| 25. | Excessive gas and / or bloating | 1 | 2 | 3 | 4 |
| 26. | Do you have bright red blood on the tissue paper after a bowel movement | 1 | 2 | 3 | 4 |

27.	Pain and / or discomfort in the head, neck and / or body between 5:00 – 7:00 am	1	2	3	4
28.	Coated tongue	Yes			
29.	Feel worse in moldy, musty or damp place	Yes			
30.	Taken any type of antibiotics for a period of time	Yes			
31.	Fungus or yeast infections	Yes			
32.	History of ring worm, “jock itch”, “athletes foot”, nail fungus	Yes			
33.	Eating sugar, starch or drinking alcohol increases yeast symptoms	Yes			
34.	History of parasites	Yes			
35.	Irritable bowel or colitis	Yes			
36.	Painful to press along the outer sides of the thighs	Yes			
37.	Dark circles under the eyes	Yes			
38.	Rash under breast, armpit around navel or groin area	Yes			
39.	Currently on medication for IBS, Colitis, Crohn’s, or other bowel conditions	Yes			
40.	Do you use natural, over the counter or prescription laxatives	Yes			
41.	Recurrent infections and / or colds	Yes			
42.	History of constipation	Yes			
43.	Do you have itching, burning pain and / or swelling in the rectal area	Yes			
44.	Do you have hemorrhoids	Yes			



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