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Tel 01223 830118 Mob 07904 934213

Colon Hydrotherapy Questionnaire

Private and Confidential

Please fill out this form and bring it with you to you first consultation.

Name: _____Date of Birth_____

Address: _____

_____

Tel:_____Mob:_____Email:_____

Occupation: _____

G.P. Name and Address:_____

_____

Marital Status:_____Children?_____

Please state your reason for wanting Colonic Hydrotherapy_____

_____

_____

Do you or have you suffered from?

Abdominal pain ☐	Bad breath ☐	Colitis ☐	Constipation ☐
Diarrhoea ☐	Bloating ☐	Diverticulitis ☐	Flatulence ☐
Gall bladder problems ☐	Heartburn ☐	Indigestion ☐	I.B.S. ☐
Rectal bleeding ☐	Rectal itching ☐	Ulcerative Colitis ☐	Sluggish Bowel ☐

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How many Bowel movements do you have daily?_____

Are you pregnant?_____

Please state all medications currently being taken, including herbal and state length of time taken_____

_____

Please state all conditions being currently treated_____

_____

_____

Please state all past medical conditions and surgeries and dates:_____

_____

_____

Are you consulting any other practitioners? Please give details: _____

_____

_____

_____

Do you or have you ever suffered from:
(please tick and give details below)

Hemorrhoids ☐	High blood pressure ☐	Heart disease ☐	Fissures/Fistulas ☐
Bowel perforation ☐	Colon/Rectal cancer ☐	Colon surgery ☐	Severe Anaemia ☐
Liver Cirrhosis ☐	Kidney failure ☐		

Please Provide Details:

_____

_____

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Do you or have you suffered with any of the following? Please indicate if current or in the past and give details below:

Alcoholism ☐	Cancer ☐	M.E. ☐	Diabetes ☐
Drug Addiction ☐	Weight-loss ☐	Low blood pressure ☐	Epilepsy ☐
Hepatitis ☐	HIV/AIDS ☐	Hypoglycemia ☐	Thyroid problems ☐
Headaches ☐	Angina ☐	Poor circulation ☐	Heart Problems ☐
Anxiety ☐	Depression ☐	Nervous breakdown ☐	Insomnia ☐
Mood swings ☐	Stress ☐	Concentration issues ☐	Fatigue ☐
Exhaustion ☐	Panic Attacks ☐	Mental health issues ☐	Bladder infection ☐
Thrush ☐	Cystitis ☐	Kidney infections ☐	Period problems ☐
Endometriosis ☐	Miscarriage ☐	Skin conditions ☐	Chest conditions ☐
Sinus problems ☐	Allergies ☐	Prone to getting colds ☐	Arthritis ☐
Muscle pain ☐	M.S. ☐	Joint pain ☐	Back pain ☐
Bulimia ☐	Anorexia ☐	Enlarged Prostate ☐	

Relevant Details

_____

_____

_____

Is there a family history of any of the following? (please circle):

Crohn's disease I Colitis I Heart disease I Cancer I Diabetes I Asthma

Please Give Details

_____

_____

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Do you?

	Number	Frequency
Smoke		Cigarettes Per Day
Drink Tea		Cups Per Day
Drink Coffee		Cups Per Day
Fizzy/Soft Drinks		Cans Per Day
Water		Glasses Per Day

How often do you exercise ?

_____

_____

_____

How much sleep do you need ____ hours per night

How much sleep do you get ____ hours per night.

Eat meat/fish YES ☐ NO ☐

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Please complete this food diary for the past 3 days:

	Breakfast	Lunch	Dinner	Snacks
Day 1				
Day 2				
Day 3				

Other information

_____

_____

This information is to the best of my knowledge true and accurate. Colonic Hydrotherapy has been fully explained to me and I give my consent for a digital examination and the procedure of Colonic Hydrotherapy to be performed on myself/ my child.

Signed_____Date_____