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:_____

_____B.P_____

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 ☐

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:

_____

_____

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

_____

_____

Do you?

	Number	Frequency
Smoke		Cigarettes Per Day
Alcohol		Units per week
Drink Tea		Cups Per Day
Drink Coffee		Cups Per Day

	Number	Frequency
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 □

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 rectal examination (DRE) and subsequent colon hydrotherapy treatments and that the data herein collected may be used and held securely and confidentially under GDPR 2018 guidelines.

I have read and fully understand the Contra Indicated conditions and confirm the absence of such conditions.

I agree to my health record being kept securely by the therapist for a minimum of 7 years.

In the event of suffering ill health during the treatment i give consent for the following actions to be taken: Administer my medication/ call an ambulance/ call a relative/ discontinue treatment/ position comfortably. (Delete where appropriate)

Signed by client_____Signed by therapist _____
Date_____