**HEALTH QUESTIONNAIRE**

**In strictest confidence**

**Personal details**

|  |  |
| --- | --- |
| Full name: | Telephone contact details: |
| Address & postcode: |
| Email address: We only use this to respond to queries and won’t share it with a third party. |
| Date of birth & age: | Occupation: |
| Height: | Weight: |
| Emergency contact details: |
| Dependents: please give details, including ages of children. |
| Do you have any pets? Please give details. |
| What is your main reason for seeking help through colonic hydrotherapy? |

**Official use only –** to be completed at first appointment

|  |  |  |
| --- | --- | --- |
| Date of first treatment: | Blood pressure | Pulse rate: |

**Medical information and history**

|  |
| --- |
| GP name and practice address: |
| Have you suffered from high blood pressure? Yes ☐ No ☐ | Blood group (if known): |
| Do you have any current health complaints? Yes ☐ No ☐If yes, give details. |
| Are you currently consulting: please ✓all that apply. |
| Health professional ☐  | GP ☐  | Holistic health practitioner ☐  |
| If so, for what? |
| Have you received any antibiotic or steroid-based treatment in the last six months? Yes ☐ No ☐If yes, please give details, including the approximate date you stopped taking them. |
| Are you currently taking any other prescribed medication? Yes ☐ No ☐ If yes, please give details… |
| Have you ever taken: please ✓ all that apply.* recreational drugs ☐
* steroid-based medication? ☐
 |
| Any past medical problems / surgical procedures? Yes ☐ No ☐ If yes, give details. |
| Were you born: please ✓* by caesarean ☐
* naturally? ☐
 | Were you: please ✓* breast fed ☐
* bottle fed? ☐
 |

|  |
| --- |
| Have you ever been hospitalised, as a baby, child or adult for an infection that required antibiotics, particularly intra-venous antibiotic? Yes ☐ No ☐If yes, please state what for, when and the duration of your stay. |
| Have you ever had enemas or colonic treatment before? Yes ☐ No ☐ |
| Have you had any rectal problems in the past? Yes ☐ No ☐ |
| What are your bowel-emptying habits? Please detail frequency, size, shape, consistency, colour, feeling empty afterwards. |
| Do you ever have any mucous in your stools? Yes ☐ No ☐ |
| Does stress affect your bowel movements? Yes ☐ No ☐ |
| How often do you urinate during a day? |

**Procedures**

|  |
| --- |
| Have you ever had any of these procedures? Please ✓ all that apply. |
| * Colonoscopy ☐
 | * Barium enema ☐
 |
| * Endoscopy ☐
 | * Abdominal scans ☐
 |

**Contra-indications section**

Please tick if you suffer from, or ever have suffered from, any of the following conditions…

|  |  |  |  |
| --- | --- | --- | --- |
| **General** | ✓ | **Gastro-intestinal** | ✓ |
| Alcoholism |  | Abdominal pain |  |
| Amalgam fillings – how many? |  | Bad breath |  |
| Anaemia |  | Colitis  |  |
| Cancer |  | Constipation |  |
| Chronic Fatigue Syndrome |  | Cravings |  |
| Diabetes |  | Diarrhoea |  |
| Dizziness |  | Distension / abdominal bloating |  |
| Double / blurred vision |  | Diverticulitis / diverticulosis |  |
| Drug addition |  | Heartburn |  |
| Fainting spells |  | Indigestion |  |
| Ear infections |  | Irritable Bowel Syndrome, IBS |  |
| Epilepsy |  | Liver trouble, such as fatty liver, cirrhosis |  |
| Headaches / migraines |  | Rectal bleeding |  |
| Hepatitis |  | Rectal itching |  |
| HIV / Aids |  | Ulcerative colitis |  |
| Hypoglycaemia |  | **Emotional / nervous system** | ✓ |
| Gallstones |  | Anxiety |  |
| M.E. |  | Depression |  |
| Over-active thyroid |  | Fatigue |  |
| Under-active thyroid |  | Insomnia |  |
| Weight loss |  | Irritability |  |
| **Cardio-vascular** | ✓ | Lack of concentration |  |
| Angina / chest pains |  | Lethargy |  |
| Hardening of the arteries |  | Mood swings |  |
| Low blood pressure |  | Over-reacting |  |
| Rapid, irregular heartbeat |  | Panic attacks |  |
| Swelling of the ankles |  | Memory loss |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Muscle and joint** | ✓ | **Women** | ✓ |
| Arthritis |  | Amenorrhea (absence of periods) |  |
| Low back pain |  | Dysmenorrhea (painful periods) |  |
| Joint pain / stiffness |  | Endometriosis |  |
| Rheumatism |  | Genital herpes |  |
| Muscle weakness |  | Genital warts |  |
| **Skin** |  | Heavy menstrual flow |  |
| Acne |  | Hysterectomy |  |
| Bruise easily |  | PMT |  |
| Dermatitis |  | Vaginal thrush |  |
| Eczema |  | Are you pregnant? Yes ☐ No ☐ |
| Fungal infections |  | Date of last period |
| Psoriasis |  | Are you on the pill? Yes ☐ No ☐ |
| **Respiratory** | **✓** | **Men** | **✓** |
| Asthma |  | Enlarged prostate |  |
| Bronchitis |  | Genital herpes |  |
| Emphysema |  | Genital warts |  |
| Hay fever |  | **Other – please give details below** |
| Sinus problems |  |  |
| C.O.P.D |  |
| **Genito-urinary** | ✓ |
| Bladder infections |  |
| Kidney infections / stones |  |
| Kidney failure |  |

**Lifestyle**

|  |
| --- |
| How many hours do you sleep a night? |
| * More than 8 hours ☐
 | * Less than 8 hours ☐
 |
| How often do you exercise? |
| * Every day ☐
 | * 2-3 times a week ☐
 | * Not at all ☐
 |
| How many cups of tea, coffee or water do you drink a day? |
| * Tea \_\_\_\_\_\_\_\_
 | * Coffee \_\_\_\_\_\_\_\_
 | * Water \_\_\_\_\_\_\_\_
 |
| How much alcohol do you drink a week? |
| Do you smoke? Yes ☐ No ☐  | If yes, how many a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If you no longer smoke, when did you stop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you a frequent traveller abroad? Yes ☐ No ☐If yes, have you ever suffered from sickness and diarrhoea Yes ☐ No ☐ |
| Do you feel you are under a lot of stress at the moment? Yes ☐ No ☐If yes, how would you rate the level of stress you’re feeling? On a scale of 1 to 10 where 1 is not feeling stressed at all and 10 is feeling very stressed? \_\_\_\_\_\_\_\_\_Do you know the cause? Yes ☐ No ☐ If yes, please give details. |

**Diet**

|  |
| --- |
| Please describe your current eating habits on an average day…Breakfast:Lunch:Dinner:Snacks |
| Which foods do you avoid due to allergy or intolerance? |
| Are there any foods you believe do not suit you? |
| Which foods do you eat every day and could not give up? |
| Are you: |
| * Vegetarian ☐
 | * Vegan ☐
 |
| Are you taking any vitamin / mineral supplements? Yes ☐ No ☐  |
| Have you ever suffered from an eating disorder, including over-eating? Yes ☐ No ☐ If yes, give details. |
| Have you suffered with gastroenteritis or had any other gastric upsets? Yes ☐ No ☐ If yes, give details… |
| Any other relevant information: Please use this space to add any details you feel aren’t covered elsewhere. |
| How did you hear about the Colonic Hydrotherapy Clinic? Please give details. |

**Consent form**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** agree to an examination and colonic irrigation treatments.

To the best of my abilities, I have informed my therapist of any medical conditions, medication and surgery that could affect my treatment.

I understand that colonic irrigation is part of an overall approach to diet and lifestyle and is not a medical treatment.

The medical conditions that are contra-indicated with colonic irrigation are:

|  |  |
| --- | --- |
| * recent surgery to the rectum or abdomen (less than 8 weeks)
 | * blood pressure above 160/100
* pregnancy
 |
| * abdominal hernia
 | * heart disease
 |
| * severe haemorrhoids
 | * kidney disease
 |
| * fissures
 | * severe anaemia
 |
| * fistulas
 | * severe or uncontrolled diabetes
 |
| * bowel perforation
 | * long-term oral steroid use.
 |
| * cancer of the rectum or bowel
 |  |

I have informed my therapist of any possible latex allergy.

The information provided within this form is, to the best of my knowledge, true and accurate.

I also confirm that I have not withheld any health or personal information that may affect the therapist’s decision to treat me with colon hydrotherapy.

I also agree to have a rectal examination, if during discussion, this is considered necessary.

I suffer from diabetes / angina / epilepsy / heart disease / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_condition (delete or add, as appropriate).

In the event of an attack, I consent to the following action being taken:

☐ administer my medication

☐ call an ambulance

☐ call my emergency contact

☐ position comfortably

☐ other, please state… \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All of the information within this form is for Colon Hydrotherapy Clinic purposes only and will not be shared with other companies.**

Thank you.