THE COLON HYDROTHERAPY CLINIC

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 ☐
- Endoscopy ☐
- Barium enema ☐
- 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)
- abdominal hernia
- severe haemorrhoids
- fissures
- fistulas
- bowel perforation
- cancer of the rectum or bowel
- blood pressure above 160/100
- pregnancy
- heart disease
- kidney disease
- severe anaemia
- severe or uncontrolled diabetes
- long-term oral steroid use.

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.