Colon Hydrotherapy Questionnaire

All information provided in this questionnaire will be treated in the strictest confidence.

Full Name: ____

Address: ____

Telephone No: (Home) ____________MOB____________ Email: ____________

Date of Birth: __________ Age: ______ Height: ________ Weight: __________

Occupation: ____

Name and Address of G.P.: ____

____

Do I have your consent to contact your G.P. if necessary? YES / NO

Marital Status: Single/Partner/Married/Separated/Widowed/divorced Do you have any children? ______

Are you currently receiving medical treatment from your G.P. or hospital? YES / NO

If yes please list condition(s) being treated: ____

____

Please list all medications you are currently taking: ____

____

List all past medical conditions with approximate dates: ____

____

____

____

List all past surgical procedures with approximate dates: ____

____

____

List any vitamin / mineral supplements you are currently taking: ____

____

Are the above prescribed or self-prescribed? ____

How long have you been taking the supplements? ____

Are you currently consulting any other practitioners? Please give details of treatments you are receiving:

____

Please list any herbs and / or homeopathic remedies being used: ____

____

Do you suffer from, or have you ever suffered from:

High blood pressure	YES / NO	Kidney failure	YES / NO
Heart Disease	YES / NO	Cirrhosis of the liver	YES / NO
Severe Haemorrhoids	YES / NO	Cancer of the Colon or Rectum	YES / NO
Abdominal of Inguinal Hernia	YES / NO	Recent colon or rectal surgery	YES / NO
G.I. Haemorrhage / Perforation	YES / NO	Severe Anaemia	YES / NO
Fissures / Fistulas	YES / NO		

If you have answered YES to any of the above please give details: ______________________________

____

Please tick if you suffer or have suffered from any of the following conditions:

General	Current	Past	**Genito-Urinary**	Current	Past
Alcoholism	❑	❑	Bladder infection	❑	❑
Anaemia	❑	❑	Kidney infections/stones	❑	❑
Cancer (of any type)	❑	❑	Painful urination	❑	❑
Chronic Fatigue Syndrome	❑	❑	Recurring cystitis	❑	❑
Diabetes	❑	❑			
Dizziness	❑	❑	**Muscle & Joints**		
Double / blurred vision	❑	❑	Arthritis	❑	❑
Drug Addiction	❑	❑	Lower back pain	❑	❑
Fainting spells	❑	❑	Joint pain / stiffness	❑	❑
Ear infections	❑	❑	Multiple sclerosis	❑	❑
Epilepsy	❑	❑	Muscle weakness	❑	❑
Headaches / Migraine	❑	❑	Swollen joints	❑	❑
Hepatitis	❑	❑			
HIV / AIDS	❑	❑	**Respiratory**		
Hypoglycaemia	❑	❑	Asthma	❑	❑
M.E.	❑	❑	Bronchitis	❑	❑
Loss of weight	❑	❑	Emphysema	❑	❑
Over-active thyroid gland	❑	❑	Hay fever	❑	❑
Under-active thyroid gland	❑	❑	Shortness of breath	❑	❑
			Sinus problems	❑	❑
Cardiovascular			Tuberculosis	❑	❑
Angina (chest pain)	❑	❑			
Hardening of the arteries	❑	❑	**Skin**		
Low blood pressure	❑	❑	Acne	❑	❑
Poor circulation	❑	❑	Bruise easily	❑	❑
Rapid /irregular heartbeat	❑	❑	Dermatitis	❑	❑
Swelling of the ankles	❑	❑	Dryness	❑	❑
			Eczema	❑	❑
Emotional / Nervous System			Fungal infections	❑	❑
Anxiety	❑	❑	Itching	❑	❑
Depression	❑	❑	Psoriasis	❑	❑
Fatigue	❑	❑			
Insomnia	❑	❑	**Women**		
Irritability	❑	❑	Abortion	❑	❑
Lack of concentration	❑	❑	Amenorrhoea (absence of periods)	❑	❑
Lethargy	❑	❑	Dysmenorrhoea (painful periods)	❑	❑
Mood swings	❑	❑	Endometriosis	❑	❑
Nervous breakdown	❑	❑	Genital Herpes	❑	❑
Nervous exhaustion	❑	❑	Genital Warts	❑	❑
Over-reacting	❑	❑	Heavy menstrual flow	❑	❑
Panic attacks	❑	❑	Hysterectomy	❑	❑
Poor memory	❑	❑	Infertility	❑	❑
Schizophrenia	❑	❑	Miscarriage	❑	❑

	Current	Past
Gastro-Intestinal		
Abdominal pain	❑	❑
Bad breath	❑	❑
Colitis	❑	❑
Constipation	❑	❑
Diarrhoea	❑	❑
Distension & bloating of abdomen	❑	❑
Diverticulitis / Diverticulosis	❑	❑
Excessive Flatulence	❑	❑
Gall bladder disease	❑	❑
Heartburn	❑	❑
Indigestion	❑	❑
Irritable bowel syndrome	❑	❑
Liver trouble	❑	❑
Rectal bleeding	❑	❑
Rectal itching	❑	❑
Ulcerative Colitis	❑	❑
Vomiting of blood	❑	❑

	Current	Past
PMT	❑	❑
Prolapsed womb	❑	❑
Scant menstrual flow	❑	❑
Too frequent periods	❑	❑
Vaginal Thrush	❑	❑

Are you pregnant? YES / NO

If yes how many weeks? _______________

Date of last menstrual period _______________

Do you take the contraceptive pill or HRT? YES/NO

Do you use an IUD? YES / NO

Men

	Current	Past
Enlarged Prostate		
Genital Herpes	❑	❑
Genital Warts	❑	❑
Impotence	❑	❑
Low sperm count / mobility	❑	❑

Do you have a family history of the following conditions?

Crohn's disease	YES / NO
Ulcerative colitis	YES / NO
Heart disease	YES / NO
Cancer	YES / NO
Diabetes	YES / NO
Asthma	YES / NO

Do you smoke? YES / NO How many per day? _________________________________

Do you drink alcohol? YES / NO How many units a week? _____________________________

Do you drink tea? YES / NO How many cups per day? _____________________________

Do you drink coffee? YES / NO How many cups per day? _____________________________

Do you drink soft drinks (cola etc) YES / NO How many glasses per day? ___________________________

Do you drink water YES / NO How many glasses per day? ___________________________

Do you exercise? YES / NO How often? ____

Do you take recreational drugs? YES / NO What type and how often? _____________

How regular are your bowel movements? __

What is the consistency?___________________

Do you feel incomplete?___________________

How many hours sleep do you get / need? ____

Do you have a good appetite? YES / NO

Do you suffer from any allergies / food sensitivities? If yes please list YES / NO ____

Do you frequently travel abroad ____

Are you under a lot of stress? ______________________________

Daily Diet

Please give an indication of your typical daily diet

Breakfast: ______________________________

Mid Morning: ______________________________

Lunch: ______________________________

Mid Afternoon: ______________________________

Dinner: ______________________________

Have you ever suffered from Anorexia or Bulimia? YES / NO

Are you Vegetarian or Vegan? ______________________________

Additional Information

Please give any other information that you think is relevant. ______________________________

____

Main reason for wanting Colon Hydrotherapy? ______________________________

Recommended by / saw advertisement: ______________________________

The information provided above is, to the best of my knowledge, true and accurate. The procedure for colon hydrotherapy has been explained and I hereby give my consent for a digital examination and colon hydrotherapy to be performed on myself / my child.

Signature: ______________________ Date: ______________________

THE CLINIC ADDRESS IS 5 THREE HILL VIEW GLASTONBURY SOMERSET BA6 8AU

THERE ARE QUITE A LOT OF STEPS UP TO THE CLINIC SO PLEASE MAKE SURE YOU ARE ABLE BODIED

Practitioners Record

Date						
Weight (before/after)						
Abdominal distension						
Pain on examination						
Scope used / insertion						
Consistency						
Undigested food						
Mucous						
Gas						
Colour						
Candida						
Parasites						
Herbs used						
Implant						

Other Observations / Recommendations / Supplements prescribed: ______________________________