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Colon Hydrotherapy Questionnaire

Full Name:

Address:

Telephone: **Email:**

Occupation: **Date of Birth:**

How did you hear about us?

Please list any conditions for which you are currently being treated:

Women Only:

Are you pregnant? Y/N Are you trying to conceive? Yes/ NO

Do you have children? Y/N How Many? ____________ How Old? _______________

Medications:

Drug Name	Dosage	Condition Being Treated	Duration

Supplements & Herbs:

Names	Dosage	Condition Being Treated	Duration

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What are your main health concerns? (*Please tick/ circle all that apply to you)*

General

- Alcoholism
- Allergies
- Anaemia
- Cancer
- Diabetes
- Dizziness/ Fainting Spells
- Ear problems
- Anorexia/ Bulimia
- Epilepsy
- Eye Problems
- Gout
- Headaches
- Migraines
- Hepatitis
- Hernia
- HIV / AIDS
- Hypoglycaemia
- Kidney Problems
- Liver Problems
- ME
- MS
- STI/ STD's
- Thyroid Problems
- Weight Problems
- Visual Floaters
- Other:

  ____

Emotional/Nervous System

- Anxiety or Stress
- Depression
- Fatigue
- Hyperactive
- Insomnia / Sleep Problems
- Irritability
- Lack of Concentration
- Lethargy
- Mood Swings
- Panic Attacks
- Poor Memory
- Eye Tics
- Pins & Needles
- Other:

  ____

Gastrointestinal

- Abdominal Pain
- Bad Breath
- Bloating
- Bloody / Black Stool
- Candida
- Colitis
- Constipation

  If so for how long?

  ____

- Colon / Rectum Cancer
- Diarrhoea
- Diverticulosis
- Food Cravings
- Gastrointestinal Infections / Bugs
- Haemorrhoids
- Heartburn / Reflux
- IBS
- Indigestion
- Jaundice
- Mucus In Stools
- Rectal / Anal Bleeding
- Rectal / Anal Itching
- Ulcers
- Other:

  ____

Cardiovascular

- Angina/ Heart Problems
- Blue/ Cold Extremities
- Chest Pains
- Low/ High Blood Pressure
- Palpitations
- Poor Circulation
- Swelling Of Ankles/ Legs
- Varicose Veins
- Other:

  ____

Women

- Acne
- Breast Problems
- Caesarean Section
- Endometriosis/ Fibroids
- Poly Cystic Ovarian Syndrome
- Excessive Hair Growth
- Genital Herpes
- Genital Warts
- Hair Loss
- Having Difficulty Conceiving
- Hysterectomy
- Low Sex Drive
- Contraception Type:

  ____

- Miscarriage
- Painful / Heavy Periods
- Age of 1st Period _____
- Regular Periods
- Termination
- Thrush / Cystitis
- Water / Fluid Retention

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Skin

- Athletes Foot
- Bruise Easily
- Dermatitis
- Eczema
- Irritations
- Itching / Rashes
- Psoriasis
- Verrucas / Warts

Muscles & Joints

- Arthritis
- Back Pain
- Joint Pain/Stiffness
- Muscle Cramping
- Restless Legs
- Other:

____

Respiratory

- Asthma
- Breathlessness
- Bronchitis
- Constant Runny Nose
- Hay Fever / Rhinitis
- Persistent Cough/ Phlegm
- Sinus Problems/ Infections
- TB
- Smoking
- Other:

____

Immune System

- Allergies / Intolerances
- Coated Tongue
- Cold Sores
- Frequent Mouth Ulcers
- Reg Infections_________
- Nail Infections
- Regular Antibiotics
- Regular Colds/ Flu
- Traveller's Bugs
- Other Problems:

____

Men

- Acne
- Enlarged Prostate
- Excessive Sweating
- Frequency of Urine
- Urination Overnight
- General Herpes
- Genital Warts
- Infertility
- Other:

____

Investigations & Operations:

- X-Ray/ Scans: ______________________________
- Barium Meal: ______________________________
- Colonoscopy: ______________________________
- Endoscopy: ______________________________
- Biopsies: ______________________________
- Surgeries: ______________________________

____

____

Please list all recurring illnesses/diseases that occur within the family:

- Grandparents: ______________________________
- Parents: ______________________________
- Siblings: ______________________________

____

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What are your current bowel habits?

Frequency (per day/week) ____________ Present Consistency (skinny/ pellets/ loose)_______________

*Gas *Bloating *Mucous *Bleeding

Are you currently taking or have you used laxatives in the past? Y/N Types _______________________

What would you like to achieve from this treatment?

____

____

Diet: (*Please list a typical day)*

Breakfast: ____

____

Snacks: ____

Lunch: ____

____

Snacks: ____

Dinner: ____

Snacks: ____

Please list quantity of fluids per day & state if caffeinated or de-caff:

Tea: _______ Coffee: _______ Water: ______ Proteins Shakes: ___________ Others: _____________

Please list any foods you crave:

____

Please list units of alcohol consumed per week: (*1 unit=1 small glass of wine, half pint of beer, small spirit*)

____

Do you wake up fresh in the morning? Y/ N

Do you need Tea/ Coffee/ Sugar to wake up in the mornings? Y/ N

Do you need Tea/ Coffee/ Sugar at regular intervals? Y/ N

Do you get Dizzy/ Irritable without regular food? Y/ N

Do you get tired particularly after lunch? Y/ N

Do you have poor Memory/ Concentration? Y/ N

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Declaration

1. I confirm that all information included in this questionnaire is correct to the best of my knowledge and I have informed the practitioner of all health issues and have not knowingly withheld any information.
2. I understand that colon hydrotherapy is part of an overall approach to diet and lifestyle.
3. I agree to have a digital examination, this ensures that there are no obstructions or lesions which may prevent the insertion of the speculum.

Signed: ______________________________

I have read and do not have any of the following contraindications that would prevent me from having this treatment:

Cancer, Colon/Rectal Surgery, Inflammatory Bowel Disease/ Colitis, Diverticulitis, Severe Haemorrhoids, Gastrointestinal Bleeding, Abdominal Hernia, Enlarged Prostate, Fissures or Fistula, Pregnancy, Cardiac Disease/ Unstable or High Blood Pressure, Renal Insufficiency, Liver Disease, Insulin Dependant/Unstable Diabetes, Severe Gallstones, Antibiotics.

Signed: ______________________________ Date: ________________________

Therapist: ______________________________

Lisa Manley

General Nurse & Colon Hydrotherapist

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TREATMENT 1. **Date:** ______________________

Rectum/ Anus: **Peristalsis:**

Water Volume: **Water Temp:**

Implant:

Tx Description:

___

___

___

Mucous: **Fermentation:** **Old Faeces :**

Patient Response:

___

___

After Care/ Supplementation:

___

___

___

TREATMENT 2. **Date:** ______________________

Client Feedback:

___

___

Rectum/ Anus: **Peristalsis:**

Water Volume: **Water Temp:**

Implant:

Tx Description: ______________________

___

___

Mucous: **Fermentation:** **Old Faeces:**

Patient Response: ______________________

After Care Advice/ Supplementation:

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