**Colon Hydrotherapy Health Questionnaire**

**Please fill out and bring to your treatment.**

All information is treated in the strictest of confidence and no information will be shared to a third party.

**Name:** ___________________________________________________________

**Address**: ________________________________________________________________________________

________________________________________________________________________________

**Tel**: _____________________ **Email**:__________________________________________________

**Date of birth**: _____________________________

**Medical History & Current Health**

Are you being treated for any medical condition, if so explain details

________________________________________________________________________________

Have you ever had, or do you currently suffer from, any of the following?

Migraines ı Anaemia-Tinnitus ı High / low blood pressure ıHay fever ı Skin problems Asthma ı Rheumatism I Bronchitis ı Gout ıBack problems ı Arthritis I Neuralgia ı Haemorrhoids I Ulcers ı Diabetes ıHerpes ı Gallstones I Diverticulitis ı Stomach problems kidney problems ı Cystitis ıIBS ı Colitis ıHernia ı Anal fissures ı

Do you experience any of the following?

Flatulence ı Heartburn ıIndigestion ı Nausea ıBloating ı Constipation ıDiarrhoea ı Faeces that seem to be a strong colour ıBlood or mucus in your faeces ı Faeces with a strong odour ıPain/difficulty having a bowel movement ı Other digestive problems ıMucus or catarrh ı Frequent colds ıCold sores ı Cracked skin ıSensitive gums ı Throat infections ıDizziness or light-headedness ı Runny or itchy eyes ıMouth ulcers or gum boils ı

How often do you have a bowel movement? _______________________________________

Are you on any form of medication? Yes / No

Name of the medication and length of time on it
___________________________________________________________________

Do you take any daily vitamins or nutritional supplements? Yes / No

Name(s) of vitamins / supplements taken
___________________________________________________________________________________________
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Have you taken any of the following medications, or any other medication not specified, for an extended period?

Antibiotics Yes / No Steroids Yes / No

Cortisone Yes / No Heart drugs Yes / No

Diuretics Yes / No Other (please specify): ________________________

**Diet**

Please write down what you eat and drink on a typical day, including quantity.

Breakfast _____________________________________________________________________

Lunch _____________________________________________________________________

Dinner _____________________________________________________________________

Snacks _____________________________________________________________________

How much water do you drink? _______________________________________________________

Other drinks: _____________________________________________________________________

Are you allergic/intolerant to any foods or drinks? Yes / No

______________________________________________________________

Do you crave any of the following?

Sweet things ı Salty things ıCoffee ı Tea ıNicotine ı Chocolate ıAlcohol ı Anything else (please specify):

____________________________________

Are there any foods you find it hard to digest? Yes / No

______________________________________________________________

**Family history**

Have any of your parents, grandparents, brothers or sisters had any health problems? Yes / No

If yes, who and what? ____________________________________________________________________________

**Operations**

Have you ever had any operations, including any minor operations? Yes / No

If Yes, please state what the operation was for and the age you were at the time:_________________________________________________________________________________

**Health**

What aspects of your health would you like to improve?

_____________________________________________________________________________________

**Women only**

Pre-menstrual tension Yes / No

Menopausal symptoms Yes / No

Cervical erosion Yes / No

Pelvic inflammatory disease Yes / No

Thrush or other vaginal discharge Yes / No

Are you pregnant? Yes / No

**Men Only**

Thrush Yes/No

Prostate Problems Yes/No

Cystitis Yes/No

**Contraindications**

**The Following is a list of contraindications to Colon Hydrotherapy.** If you have ever been diagnosed with ANY of these conditions a colonic should not be administered OR should be used with CAUTION. A Doctors note MAY be required.

Abdominal Hernia Abdominal Surgery (Recent)

Anaemia (severe)

Carcinoma of the Colon

Severe Cardiac Disease (uncontrolled hypertension)

Crohn's Disease

Colon Surgery

Fissures Fistulas and Fissures

Lupus

Rectal Surgery

Long term steroid use

Acute Liver Failure

Aneurysm

Severe Haemorrhoids

Cirrhosis

Ulcerative Colitis

Dialysis

GI Haemorrhaging/Perforation

Pregnancy

Renal Insufficiencies

**Consent** "I confirm that the information given above is complete and correct to the best of my knowledge and belief. I also understand that I must inform my therapist of any changes in the above information, or in any other health considerations, before any subsequent treatments, I also agree that the therapist may perform a rectal examination prior to my treatment.

Signature: ______________________________ Date:___________________________________