For office use only – Base BP	

Colonic Healthcare

Colonic Hydrotherapy Health Questionnaire

Please fill in this questionnaire and bring it with you to your treatment.

Surname:	E-Mail:	
Name:	Mobile:	
Address:	Telephone No:	
	Occupation:	
	Date of Birth:	
	Age:	Sex:
Have you had colonics before: Y N	Weight:	Height:

Reasons for the treatment (tick the ones that apply to you):

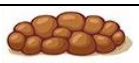
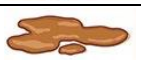
Kick-start healthy living		Irregular bowel movements		Lack of energy		Skin problems	
Detox		Constipation		Food cravings		Allergies	
Increase energy		IBS/Bloatedness		Mood swings		Parasites	
Help with weight loss		Diarrhoea		Yeasts/Candida		Headaches/migraines	
Other:							

Please state your occupation and describe the levels of stress, *a typical workday eating pattern*, including meals, snacks and liquid intake. If you smoke or drink alcohol *please state how much*.

Describe your typical bowel movements:

How regular are your bowel movements:	

(Please circle Type)

Type 1		Separate hard lumps, like nuts (hard to pass)	Type 5		Soft blobs with clear-cut edges (easy to pass)
Type 2		Sausage shaped, but lumpy	Type 6		Fluffy pieces with ragged edges, mushy
Type 3		Sausage shaped, but with cracks on the surface	Type 7		Watery, no solid pieces (entirely liquid)
Type 4		Sausage or snake like, smooth and soft			

Please describe the colour:	

Is there ever mucus in your stools	Yes		No		Do you take Laxatives	Yes		No	
Does stress affect your bowel movements	Yes		No		Do you have Hemorrhoids	Yes		No	
Have you ever been diagnosed with Diverticuli	Yes		No		Do you suffer with bloating	Yes		No	

Please list any Medications and Nutritional Supplements you take on a daily basis:

Do you have any food allergies?	Yes		No			Are you allergic to Latex?	Yes		No	

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General Health – Please state if you have **ever** experienced any of the following:

	Yes	Details		Yes	Details
Alcoholism			Gall Stones		
Anemia			Gastro-Intestinal Hemorrhage		
Angina			Heart Disease		
Cancer (any type)			Hernia		
Cancer of the Colon			IBS		
Cancer of the Rectum			Irregular Heartbeat		
Crohns			Kidney Failure		
Colitis			Liver Cirrosis		
COPD			Liver Trouble		
Diabetes			ME		
Diverticulitis			MS		
Emphysema			Severe Anemia		
Epilepsy			Severe Hemorrhoids		
Fistulas / Fissures			Ulcerative Colitis		

General Health – Please state if you have experienced any of the following **in the past 12 months**:

	Yes	Details		Yes	Details
Abdominal Bloating			Fungla Infections		
Abdominal Pain			Hayfever		
Acne			Headaches		
Amenorrhoea			Heartburn		
Anxiety			Heavy Menstruation		
Arthritis			High Blood Pressure		
Asthma			Hysterectomy		
Bad Breath			Indigestion		
Bladder Infection			Insomnia		
Bronchitis			Joint Pain		
Bruising Easily			Kidney Infection		
Coil			Kidney Stones		
Colon Surgery			Lethargy		
Constipation			Low Blood Pressure		
Cravings			Lower Back Pain		
Depression			Mood Swings		
Dermatitis			Muscle Weakness		
Diahorea			Oral Contraceptive Pill		
Dizziness			Panic Attacks		
Drug Addiction			PMT		
Dysmenorrhoea			Pregnancy		
Endometriosis			Psoriasis		
Enlarged Prostate			Rectal Bleeding		
Eczema			Rectal Itching		
Fainting			Vaginal Thrush		
Fatigue			Weight Loss		

Has a close family member ever been diagnosed with bowel cancer, Crohn's disease, ulcerative colitis or diverticulitis?	Yes		No	

Please add any information on operations/surgeries in the last 5 years.

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Colonic Irrigation Treatment Consent Form

1. The information provided above is, to the best of my knowledge, true and accurate. I also confirm that I have not withheld any health / personal information that may affect the therapist's decision to treat me with colon hydrotherapy.

Signed:……. Date:……

2. I agree to have a rectal examination if during discussion it is deemed necessary.

Signed:……..... Date:……..

3. If suffering from diabetes, angina, heart disease or epilepsy, in the event of an attack, I agree to the following actions being taken (delete as appropriate):

- Administer my medication
- Call an ambulance
- Call a relative (Name:……. Tel:.....)
- Position me comfortably

Signed:……..... Date:……..

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