

## Colon Hydrotherapy Questionnaire

All information provided will be treated with the strictest confidence

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Tel: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_

Occupation: \_\_\_\_\_

Name & Address of GP: \_\_\_\_\_

Do I have your consent to contact your GP if necessary? YES/NO

Marital Status: Single/Married/Divorced/Separated/Widowed No. of Children \_\_\_\_\_

Current Health Complaint: \_\_\_\_\_  
\_\_\_\_\_

Please list all medications you are taking: \_\_\_\_\_  
\_\_\_\_\_

List all past medical problems with approximate dates: \_\_\_\_\_  
\_\_\_\_\_

List all past surgical procedures with approximate dates: \_\_\_\_\_  
\_\_\_\_\_

List any vitamin/mineral/herbal/homeopathic supplements you are taking: \_\_\_\_\_  
\_\_\_\_\_

Are the above prescribed/self-prescribed? How long have you been taking supplements? \_\_\_\_\_

Are you currently consulting any other practitioners? If so, please give details: \_\_\_\_\_  
\_\_\_\_\_

Have you received any antibiotic treatment in the past 2 years? YES/NO

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

High Blood Pressure	YES/NO	Kidney Disease/Failure	YES/NO
Heart Disease	YES/NO	Cirrhosis of the liver	YES/NO
Severe Haemorrhoids	YES/NO	Cancer of the Colon/Rectum	YES/NO
Abdominal/Inguinal Hernia	YES/NO	Recent Colon/Rectal Surgery	YES/NO
G.I. Haemorrhage/Perforation	YES/NO	Severe Anaemia	YES/NO
Fissures/Fistulas	YES/NO		

If you answered YES to any of the above, please give details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Natural Balance Clinic  
49 London Road, St Leonards On Sea, East Sussex TN37 6AY

<p><i>Please tick if you suffer, or have suffered from one of the following complaints:</i></p> <p><b>General</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Alcoholism</li> <li><input type="checkbox"/> Amalgam Fillings</li> <li><input type="checkbox"/> Anaemia</li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Chronic Fatigue Syndrome</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Double/Blurred Vision</li> <li><input type="checkbox"/> Drug Addiction</li> <li><input type="checkbox"/> Fainting Spells</li> <li><input type="checkbox"/> Ear Infection</li> <li><input type="checkbox"/> Epilepsy</li> <li><input type="checkbox"/> Headaches/Migraine</li> <li><input type="checkbox"/> Hepatitis</li> <li><input type="checkbox"/> HIV/AIDS</li> <li><input type="checkbox"/> Hypoglycaemia</li> <li><input type="checkbox"/> M.E.</li> <li><input type="checkbox"/> Loss of Weight</li> <li><input type="checkbox"/> Overactive Thyroid</li> <li><input type="checkbox"/> Underactive Thyroid</li> </ul> <p><b>Cardiovascular</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Angina/Chest Pains</li> <li><input type="checkbox"/> Low Blood Pressure</li> <li><input type="checkbox"/> Rapid Irregular Heart Beat</li> <li><input type="checkbox"/> Swelling of Ankles</li> </ul> <p><b>Emotional/Nervous System</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Insomnia</li> <li><input type="checkbox"/> Lack of Concentration</li> <li><input type="checkbox"/> Lethargy</li> <li><input type="checkbox"/> Mood Swings</li> <li><input type="checkbox"/> Nervous Breakdown</li> <li><input type="checkbox"/> Over-eating</li> <li><input type="checkbox"/> Panic Attacks</li> <li><input type="checkbox"/> Poor Memory</li> <li><input type="checkbox"/> Schizophrenia</li> </ul>	<p><b>Gastrointestinal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Abdominal Pain</li> <li><input type="checkbox"/> Bad Breath</li> <li><input type="checkbox"/> Colitis</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Cravings</li> <li><input type="checkbox"/> Diarrhoea</li> <li><input type="checkbox"/> Distension/Bloating</li> <li><input type="checkbox"/> Diverticulitis</li> <li><input type="checkbox"/> Excessive Flatulence</li> <li><input type="checkbox"/> Gallbladder Disease</li> <li><input type="checkbox"/> Heartburn</li> <li><input type="checkbox"/> Indigestion</li> <li><input type="checkbox"/> Irritable Bowel Syndrome</li> <li><input type="checkbox"/> Liver Trouble</li> <li><input type="checkbox"/> Rectal Bleeding</li> <li><input type="checkbox"/> Rectal Itching</li> <li><input type="checkbox"/> Ulcerative Colitis</li> <li><input type="checkbox"/> Vomiting of Blood</li> </ul> <p>Do you use laxatives? YES/NO</p> <p><b>Genito-Urinary</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bladder Infections</li> <li><input type="checkbox"/> Kidney Infections/Stones</li> <li><input type="checkbox"/> Painful Urination</li> <li><input type="checkbox"/> Recurring Cystitis</li> </ul> <p><b>Muscle &amp; Joint</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Low Back Pain</li> <li><input type="checkbox"/> Joint Pain/Stiffness</li> <li><input type="checkbox"/> Multiple Sclerosis</li> <li><input type="checkbox"/> Muscle Weakness</li> <li><input type="checkbox"/> Swollen Joints</li> </ul> <p><b>Respiratory</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Bronchitis</li> <li><input type="checkbox"/> Emphysema</li> <li><input type="checkbox"/> Hay Fever</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Sinus Problems</li> <li><input type="checkbox"/> Tuberculosis</li> </ul>	<p><b>Skin</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Acne</li> <li><input type="checkbox"/> Bruise Easily</li> <li><input type="checkbox"/> Dermatitis</li> <li><input type="checkbox"/> Dryness</li> <li><input type="checkbox"/> Eczema</li> <li><input type="checkbox"/> Fungal Infections</li> <li><input type="checkbox"/> Itching</li> <li><input type="checkbox"/> Psoriasis</li> </ul> <p><b>Women</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Absence of Periods</li> <li><input type="checkbox"/> Painful Periods</li> <li><input type="checkbox"/> Endometriosis</li> <li><input type="checkbox"/> Genital Herpes</li> <li><input type="checkbox"/> Genital Warts</li> <li><input type="checkbox"/> Heavy Menstrual Flow</li> <li><input type="checkbox"/> Hysterectomy</li> <li><input type="checkbox"/> Infertility</li> <li><input type="checkbox"/> Miscarriage</li> <li><input type="checkbox"/> PMT</li> <li><input type="checkbox"/> Prolapsed Womb</li> <li><input type="checkbox"/> Scant Menstrual Flow</li> <li><input type="checkbox"/> Too Frequent Periods</li> <li><input type="checkbox"/> Vaginal Thrush</li> </ul> <p>Are you pregnant? YES/NO If YES, how many weeks? _____</p> <p>Date of Last Period ___/___/___</p> <p>Do you take the contraceptive pill or HRT? YES?NO</p> <p>Do you use an IUD? YES/NO</p> <p><b>Men</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Enlarged Prostate</li> <li><input type="checkbox"/> Genital Herpes</li> <li><input type="checkbox"/> Genital Warts</li> <li><input type="checkbox"/> Impotence</li> </ul>																																	
<p>Do you have a family history of any of the following?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">Crohn's Disease</td> <td>YES/NO</td> </tr> <tr> <td>Ulcerative Colitis</td> <td>YES/NO</td> </tr> <tr> <td>Heart Disease</td> <td>YES/NO</td> </tr> <tr> <td>Cancer</td> <td>YES/NO</td> </tr> <tr> <td>Diabetes</td> <td>YES/NO</td> </tr> <tr> <td>Asthma</td> <td>YES/NO</td> </tr> </table> <p>If you answered YES to any of the above, please give details: _____</p> <hr/> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Do you smoke?</td> <td style="width: 33%;">YES/NO</td> <td style="width: 33%;">How many? _____</td> </tr> <tr> <td>Do you drink alcohol?</td> <td>YES/NO</td> <td>How much? _____</td> </tr> <tr> <td>Do you drink tea or coffee?</td> <td>YES/NO</td> <td>How many cups? _____</td> </tr> <tr> <td>Do you drink soft drinks (cola, etc)?</td> <td>YES/NO</td> <td>How many glasses per day? _____</td> </tr> <tr> <td>Do you drink water?</td> <td>YES/NO</td> <td>How many glasses per day? _____</td> </tr> <tr> <td>Do you exercise?</td> <td>YES/NO</td> <td>How often? _____</td> </tr> <tr> <td>Do you take recreational drugs?</td> <td>YES/NO</td> <td>How often and what type? _____</td> </tr> </table>			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? _____	Do you drink alcohol?	YES/NO	How much? _____	Do you drink tea or coffee?	YES/NO	How many cups? _____	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	How often and what type? _____
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How regular are your bowel movements? \_\_\_\_\_

Describe the colour, shape, and smell of your stool: \_\_\_\_\_

How many hours sleep do you need/get? \_\_\_\_\_

Do you have a good appetite? YES/NO

Do you suffer from any allergies/food sensitivities? YES/NO

If you answered YES to the above question, please list them: \_\_\_\_\_

Do you frequently travel abroad? YES/NO

Are you under a lot of stress? YES/NO

### Daily Diet

Please provide an indication of your daily diet

Breakfast \_\_\_\_\_

Mid Morning \_\_\_\_\_

Lunch \_\_\_\_\_

Mid Afternoon \_\_\_\_\_

Dinner \_\_\_\_\_

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

Are you a Vegetarian or Vegan? VEGETARIAN/VEGAN/NEITHER

### Additional Information

Please provide any other information you may think is relevant: \_\_\_\_\_

Main reasons for wanting Colon Hydrotherapy: \_\_\_\_\_

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 for Colon Hydrotherapy to be performed on myself/my child:

A course of Colonic Hydrotherapy treatments are non-refundable and must be completed within 6 weeks (or 3 months for a course of 6 treatments).

If a minimum of 24 hours notice is not given when cancelling or rescheduling an appointment, then this missed appointment will count as one of your treatments from the course.

Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

