



# The Colonic Clinic

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## Colonic Irrigation Questionnaire - Please fill this questionnaire and bring it with you to your treatment.

Surname:	Sex:	Have you had colonics before: Y N
Name:	Age:	What therapies do you use regularly?
Telephone No:	Weight:	
Mobile:	E-Mail:	

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

<input type="checkbox"/> Kick-start healthy living	<input type="checkbox"/> Irregular bowel movements	<input type="checkbox"/> Increase energy	<input type="checkbox"/> Skin problems
<input type="checkbox"/> Health maintenance	<input type="checkbox"/> Constipation	<input type="checkbox"/> Food cravings	<input type="checkbox"/> Allergies
<input type="checkbox"/> Detox	<input type="checkbox"/> IBS/Bloatedness	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Parasites
<input type="checkbox"/> Help with weight loss	<input type="checkbox"/> Diarrhoea	<input type="checkbox"/> Yeasts/Candida	<input type="checkbox"/> Headaches/migraines

Have these conditions lasted:      over 1-year      2-3 years      5 years or longer

### Tick the statements that apply to your eating habits and lifestyle:

<input type="checkbox"/> I have a balanced diet	<input type="checkbox"/> I don't take milk	<input type="checkbox"/> I smoke & drink	<input type="checkbox"/> I snack on sweets/chocolate
<input type="checkbox"/> I drink 8 glasses of water/day	<input type="checkbox"/> I don't eat wheat	<input type="checkbox"/> I chew thoroughly	<input type="checkbox"/> I often overeat
<input type="checkbox"/> I exercise enough	<input type="checkbox"/> I eat salads/vegetables	<input type="checkbox"/> I eat quickly	<input type="checkbox"/> I have big meals after 8 pm
<input type="checkbox"/> I do not exercise enough	<input type="checkbox"/> I eat rice, barley etc	<input type="checkbox"/> I eat ready meals	<input type="checkbox"/> I often eat bread, pasta etc

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. If you take recreational drugs please mention this to the practitioner.

Describe your typical bowel movements: frequency, amounts and appearance

### Please check whether you have any of the following conditions for which this treatment is contraindicated:

- Severe Cardiac Disease     Severe Anaemia     Active fissures/fistulae     Recent colorectal surgery     Cirrhosis or abd. hernia  
 Unmonitored High BP     GI haemorrhage/perf     Pregnancy 1st trimestre     Renal insufficiency     Colorectal carcinoma

### Please check if you have had any of the following:

- Cancer     Diabetes     High Blood Pressure     Heart Disease     Hepatitis  
 Rheumatic Fever     Thyroid Disease     Seizures     Other

Please add any information on operations/surgeries in the last 5 years (continue on the reverse if needed):

Please list any Medications and Nutritional Supplements you take on a daily basis (continue on the reverse if needed):

Please sign and date this questionnaire.

By signing this form I accept the 'Terms and Conditions of Booking' printed on the advice & reference page

Signature:

Date: