

Colonic Hydrotherapy/ Irrigation - Customer Medical Disclaimer
Please bring to your appointment completed

Client name _____
Client Address _____
Tel Home _____
Tel Mobile _____
Tel Work _____
E mail _____
Fax _____

Client Date of Birth: _____
Do you have any Children / how old: _____
Occupation _____
Hobbies _____

Name of G.P _____
Address of G.P _____

Tel Number for G.P _____

Are you taking any type of medication at present? (Even multi vitamins or homeopathic remedies or colonic irrigation) _____

Give Details

Are you receiving medical or holistic treatment of any kind at present? (Acupuncture, Aromatherapy, reflexology)

Have been in hospital for the past 5 years: _____

Details

Do you have any allergies to anything at all (nuts, wheat, nickel, dust, hay fever?)

How often do you go to the toilet and open your bowels per day

Do you have any medical condition that you feel we should know about? _____

Give details:

How many units of alcohol per week do you drink? _____

How much water per day do you drink? _____

How much caffeine do you drink per day?

How much fruit, vegetables and fibre / amount you intake per day / week

Do you have much salt in your diet? _____

Do you eat Red / white meat / vegetarian _____

Do you exercise regularly? _____

Do you use laxatives (Herbal or prescribed) if so to what frequently _____

What do you want from the colonic irrigation treatment / what are your worries and concerns

Describe your stools

- **(Tick)**
- Hard and stone like
- Light brown
- Medium Brown
- Dark brown
- Black
- Some times blood in the stools

• Do your stools float or sink

• Is it comfortable or painful to release your bowels

- Yellow
- White
- Orange

- With blood
- With large amounts of undigested food in
- Smooth
- Lumpy
- Very solid
- Painful to pass
- Diarrhoea (frequently or infrequently)

Have you ever suffered with or ever had any of the following diagnosed (tick for yes x for no)

- Head aches / Migraine
 - Food intolerances
 - Food allergies
 - Food that makes you bloat or feel ill
 - Stress
 - bloodiness
 - Fatigue
 - Tiredness
 - Insomnia
 - Poor concentration
 - Discomfort after eating
 - Bad breath, coated tongue
 - Tired eyes
 - Stiffness in the joints
 - Bad back
 - Frequent infections
 - Use antibiotics regularly
 - Hormone disruptions (PMT, Menopause, The pill, HRT use)
 - IBS (Irritable bowel syndrome)
 - Constipation
 - diarrhoea
 - Nausea
 - Flatulence
 - Indigestion
 - Candida
 - Thrush
 - Renal insufficiency
 - Are you or do you suspect you are pregnant
 - Have a lot of gas on a regular basis
 - Does your urine smell
 - Does your faeces smell
 - Skin problems of any type
 - Blemishes and skin problems on the face especially the chin area, if so when and how often.
-
-
- Dizziness

- Fainting spells
 - Excessive thirst
 - Crohns disease
 - Polycystic ovaries
 - Recent (1 year) suzerain section
 - Recent pregnancy / abortion / loss of baby _____
 - Ulcers, peptic or otherwise
-
-

- You have any gastro disorders
- Do you have to force your self to open your bowels
- Do you have any liver, Kidney, Gall blabber or pancreas illness, diseases / or have you ever had any illness related to the above
- Have you had enemas or colonic Hydro therapy previously
- Haemorrhoids
- Diverticulitis or diverticulitis
- Polyps Kidney stones
- Do you have a colostomy bag / or ever had one _____
- Surgery or cosmetic surgery on genitalia area
- Surgery or cosmetic surgery on rectum / anus
- Surgery or cosmetic surgery on stomach or diaphragm
- Have you ever had a anal / rectum tear
- Have you ever had your stomach / intestines stapled
- Hernia of any type
- Epilepsy
- Diabetes
- Skin Allergies
- Asthma
- Cancer of any type
- Eczema, Dermatitis and Psoriasis
- Heart problems/ cardio vascular disease
- Aneurisms
- Arteriosclerosis/ thrombosis/ phlebitis
- Any debilitating disease
- Anaemia
- Exophthalmic goitre
- Have you had your tonsils out _____
- Have you had your appendix out _____
- Are you taking any anti depressant medication _____
- Have any artificial valves
- Any artificial plates or pins metal or otherwise
- Any blood disorders
- Any organ disorder
- Any fungal infections
- HIV
- Hepatitis

- Joint problems
- Osteo arthritis
- Cancer, benign or malignant
- Have you ever received chemo or radio therapy
- High or low B.P
- IBS
- Digestive Disorders
- Kidney disorders
- Endocrine disorders
- Nervous disorder
- Mental illness
- Spleen / pancreas disorders
- Muscular disorders
- Have you ever had cold sores or impetigo
- Alopecia
- Do you give Blood
- Keloid Scarring
- Cosmetic surgery
- Any medical surgery of any time or aware of any in the forth coming and near future
- Have you suffered with any type of eating disorder _____

Give details

Have you ever used home enema / colonic irrigation kits or taken home enema oral or anal use tablets?

Is there a history of cancer in your family, colon or otherwise:

Your average diet per week consists of (list food and drink):

Disclaimer

I understand the information I give to be the truth and consent to the treatment of colonic irrigation/ hydrotherapy/ leverage. I have had the procedure explained to me and understand the nature of the treatment. I understand it make take several sessions to work depending on my digestive system and life style., medication and general health. I acknowledge I have given my details for the salons use. I understand my rights that my information is protected and I give my consent for the company to store and use my details. I understand that if I have been untruthful with my details or fail to give enough relevant information that could effect my treatment that I can be prosecuted by the company for misleading information.

Name (Block) _____

Date _____

Signature _____

Therapist's name _____

Date _____

Signature _____

For Therapist Use

Client posture _____

Comments:

