

# COLON HYDROTHERAPY CLIENT INFORMATION

The  
**DETOX** Studio  
taking care of you - inside & out

**PLEASE ENSURE ALL QUESTIONS ARE ANSWERED - THIS IS REQUIRED INFORMATION**  
*Please bring this form with you to your appointment.*

Client Name: \_\_\_\_\_ Treatment Number: \_\_\_\_\_

Male/Female: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Post Code: \_\_\_\_\_ Tel No: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_ How did you hear about the Studio: \_\_\_\_\_

## MEDICAL HISTORY

Dr's name and surgery address: \_\_\_\_\_

\_\_\_\_\_ Tel: \_\_\_\_\_

Medical conditions and recent surgery: \_\_\_\_\_

Blood Pressure Reading: \_\_\_\_\_

Medication: \_\_\_\_\_

## LIFESTYLE

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Married: \_\_\_\_\_ Children: \_\_\_\_\_ Occupation: \_\_\_\_\_

Exercise: \_\_\_\_\_ Do you take vitamins/minerals? \_\_\_\_\_

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

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

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

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

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

**DO YOU SUFFER FROM ANY OF THE FOLLOWING - PLEASE TICK ALL THAT APPLY:**

Bloating	_____	Colitis	_____	Constipation	_____
Carcinoma of the colon	_____	Candida	_____	Diverculitis	_____
Diarrhoea	_____	Faeces which are a dark colour	_____	Faeces with a strong odour	_____
Fissures	_____	Flatulence	_____	Haemorrhoids	_____
Pain/Difficulty Having a Bowel Movement	_____	Rectal Bleeding	_____	Cirrhosis	_____
Gall Stones	_____	Liver Trouble	_____	Indigestion	_____
Heartburn	_____	Other Digestive Problems	_____	Acne	_____
Allergies	_____	Asthma	_____	Hay Fever	_____
Itching	_____	Runny or Itchy Eyes	_____	Shortness of Breath	_____
Bronchitis	_____	Emphysema	_____	Arthritis/Rheumatism	_____
Cold Sores	_____	Frequent Colds	_____	Mucus	_____
Catarrh	_____	Throat Infections	_____	Bruise Easily	_____
Cracked Skin	_____	Diabetes	_____	Bad Breath	_____
Mouth Ulcers/Gum Boils	_____	Sensitive Gums	_____	Nausea	_____
Headaches	_____	Fatigue	_____	Thrush	_____
Dizziness/Light Headed	_____	Double/Blurred Vision	_____	Heart Condition	_____
High Blood Pressure	_____	Poor Circulation	_____	Swelling of Ankles	_____
Insomnia	_____	Loss of Weight	_____	MS	_____
ME	_____		_____		_____

## NORMAL BOWEL HABITS

Do you find any of the following in your faeces?

Blood

Mucus

Do you ever have to:

Strain

Take Laxatives

Have you ever consulted your GP due to and bowel problems?

Yes

No

Do you have bowel movements:

Daily

2/3 times a day

Every 2-3 days

Weekly

Have you ever had a colonic?

Yes

No

**Have you ever taken any of the following medications for an extended period? If so say when and what for.**

Antibiotics

Steroids

Cortisone

Heart Drugs

Diuretics

Any Others

**Do you crave any of the following?** (Please Tick)

Sweet things

Salty things

Coffee

Tea

Nicotine

Chocolate

Alcohol

Anything Else



Are there any foods or drinks you find it hard to digest? What are they?

**♀ WOMEN ONLY**

**Do you currently have or have you ever had:**

Pre-menstrual tension

Any problems with your periods

Menopausal symptoms

Cervical erosion

Pelvic inflammatory disease

Are you pregnant?

Any sexually transmitted disease

Thrush or other vaginal discharge

**♂ MEN ONLY**

**Do you currently have or have you ever had:**

Thrush

Cystitis

Prostate problems

Vasectomy

Any sexually transmitted disease

**THE FOLLOWING IS A LIST OF CONTRA-INDICATIONS FOR COLON HYDROTHERAPY TREATMENT - PLEASE ENSURE YOU TICK ANY THAT APPLY:**

Pregnancy

Severe cardiac disease

Aneurysm

Long Term Steroid Use

Cirrhosis

Fissure or Fistulas

Abdominal Hernia

Renal Insufficiency

Severe Anaemia

Severe Haemorrhoids

Carcinoma of the Colon

Recent Colon Surgery

Gastro-intestinal Haemorrhage or Perforation

# COLON HYDROTHERAPY CLIENT INFORMATION

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

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Please list any medications and nutritional supplements you take on a daily basis (continue on the reverse if needed):

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I confirm that I have to the best of my knowledge informed my therapist of any medical conditions which would affect my treatment. I understand that colon hydrotherapy is part of an overall approach to diet and lifestyle and is not a medical treatment. I have read and understood the above conditions. I do not have any of the above conditions and therefore agree to have colonic treatments.

Please sign and date this questionnaire - By signing this form I accept the 'Terms and Conditions of Booking' printed on the the advice and reference page.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ADDITIONAL INFORMATION

Please list below any further information about your health that you feel may be of importance to your treatment - if you would prefer to discuss this with your therapist in advance please call.

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## SUBSEQUENT TREATMENTS

Date	No Change to Above Signature Required	New Condition Since Last Visit Please State

(For Detox Studio Use Only)

Treatment Plan: (To include clients main reasons for treatment and how long they have had the problem.)

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Coffee enema Yes / No

Aftercare Given: \_\_\_\_\_

Any Products \_\_\_\_\_

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Future Treatment Recommendations: \_\_\_\_\_

# CANDIDA HEALTH CHECK

**TICK ALL THE QUESTIONS THAT YOU ANSWER YES TO AND ADD UP YOUR SCORE.**

<b>NO</b>	<b>QUESTION</b>	<b>POINTS</b>
1.	HAVE YOU TAKEN ANY ANTIBIOTICS WITHIN THE PAST YEAR?	20
2.	DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS: ATHLETE'S FOOT, JOCK ITCH OR VAGINITIS?	20
3.	DO YOU HAVE A SORE OR BURNING TONGUE?	20
4.	DO YOU HAVE A SMALL WHITE SPOTS OR PATCHES IN THE MOUTH AREA, WITH SWOLLEN AND SORE TISSUE AROUND THEM?	40
5.	DO YOU HAVE ALMOST CONTINUOUS FOUL SMELLING LOWER INTESTINAL GAS?	20
6.	DO YOU HAVE BLOATING AND/OR UPPER INTESTINAL GAS?	10
7.	DO YOU HAVE INDIGESTION FREQUENTLY?	10
8.	DO YOU HAVE SEVERE INSOMNIA?	20
9.	DO YOU WAKE UP SWEATING AT NIGHT?	10
10.	DO YOU HAVE STRONG CRAVINGS FOR SWEETS OR DAIRY PRODUCTS?	20
11.	DO YOU FREQUENTLY GET HIVES, RASHES OR ITCHY SKIN?	10
12.	DO YOU HAVE A LOT OF ALLERGIES?	20
13.	DO YOU USUALLY FIND IT DIFFICULT TO BREATHE THROUGH YOUR NOSE?	10
14.	DO YOU FEEL SICK ALL OVER AND DON'T KNOW THE CAUSE?	20
15.	DO YOU FEEL TIRED AND FATIGUED ALL DAY?	20
16.	DO YOU FEEL SEVERELY DEPRESSED AT TIMES?	10
17.	DO YOU FIND YOUR MEMORY FAILING YOU FREQUENTLY?	10
18.	DO YOU HAVE DISTURBANCES WITH YOUR VISION?	10
19.	DO YOU CRAVE ALCOHOLIC BEVERAGES?	10
20.	DOES TOBACCO SMOKE REALLY BOTHER YOU?	10
21.	DO YOU HAVE A LOSS OF SEXUAL DRIVE?	10
22.	DO YOU HAVE CRYING ATTACKS?	10
23.	DO YOU HAVE RECTAL ITCHING OR NASAL ITCHING?	10
24.	DO YOU FREQUENTLY BITE THE INSIDES OF YOUR CHEEKS?	10
25.	DO YOU FEEL A BURNING SENSATION WHEN YOU URINATE?	10

**YOUR TOTAL SCORE** \_\_\_\_\_

**If your score is less than 30** you probably don't have a Yeast Infection. You may want to consult your health care provider to help you assess the root cause of your condition.

**Is your score over 30 but less than 50?** Yeast Infection could be causing some of your health problems. Your condition may be mild severity with only minor physical symptoms such as food cravings or eye floaters.

**Is your score between 50 and 90?** You may have a moderate severity Yeast Infection with multiple conditions including discharges, itching, mood or emotional upsets.

**Is your score over 90?** A high score is a strong indication that you do have a Candida Albicans Yeast Infection. Your symptoms may also include depression, oral thrush, swollen tissue, discharges, foul odours, painful urination. Immediate action should be taken to get this serious health imbalance under control!