

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:

Allergies	_____	Arthritis/Rheumatism	_____	Asthma	_____
Colitis	_____	Constipation	_____	Bad Breath	_____
Diabetes	_____	Carcinoma of the colon	_____	Diverculitis	_____
Indigestion	_____	Headaches	_____	Fatigue	_____
Heart Condition	_____	High Blood Pressure	_____	Thrush	_____
Ulcers	_____	Haemorrhoids	_____	Candida	_____
MS	_____	ME	_____	Mucus	_____
Catarrh	_____	Insomnia	_____	Acne	_____
Diarrhoea	_____	Rectal Bleeding	_____	Gall Stones	_____
dizziness	_____	Liver Trouble	_____	Cirrhosis	_____
Fissures	_____	Hay Fever	_____	Loss of Weight	_____
Bronchitis	_____	Double/Blurred Vision	_____	Emphysema	_____
Poor Circulation	_____	Shortness of Breath	_____	Bruise Easily	_____
Itching	_____	Swelling of Ankles	_____		

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

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

Pregnancy	<input type="checkbox"/>	Severe cardiac disease	<input type="checkbox"/>	Aneurysm	<input type="checkbox"/>	Long Term Steroid Use	<input type="checkbox"/>
Cirrhosis	<input type="checkbox"/>	Fissure or Fistulas	<input type="checkbox"/>	Abdominal Hernia	<input type="checkbox"/>	Renal Insufficiency	<input type="checkbox"/>
Severe Anaemia	<input type="checkbox"/>	Severe Haemorrhoids	<input type="checkbox"/>	Carcinoma of the Colon	<input type="checkbox"/>	Recent Colon Surgery	<input type="checkbox"/>
Gastro-intestinal Haemorrhage or Perforation	<input type="checkbox"/>						

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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):

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.

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.)

Coffee enema Yes / No

Aftercare Given: _____

Any Products _____

Future Treatment Recommendations: _____