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HEALTH QUESTIONNAIRE
(In strictest confidence)

Full name (including title) ……..

Address (including postcode) …….

Telephone number (best to reach you on) ……..

E-mail address …….

Date of birth …….. Age …… Height ……. Weight …….

Occupation ……..

Name and address of GP …….

Blood Group (if known)……...

Have you received any antibiotic treatment in the past six months? ……..

Do you have any children? …… If yes, how old? ……..

Current health complaints ……...

……..

Please list any prescribed medications you are taking ……

……..

List all past medical problems with approximate dates ……..

……..

List all surgical procedures in the last two years ……

…….

Are you taking any vitamin/mineral supplements? ……

If so, please list ……...

Are you currently consulting any other practitioners? If so, please give details of the treatment you are

receiving …….

…….

Do you suffer from, or have suffered from:

High blood pressure ……. Kidney failure ……..

Heart disease …… Cirrhosis of the liver ……

Severe haemorrhoids …… Cancer of the colon/rectum …….

Hernia ……... Recent colon surgery ……

G.I. Haemorrhage? Severe anaemia …….
Perforation ……...

Fissures/Fistulas ……

If you have answered Yes to any of the above, please give details ……

……..

Any family health conditions ……..

……..

How often do you urinate ? 3-4 times a day …. Less …. More ….

Any back pain? Yes …… No …… How often ……

How regular are your bowel movements? ……..

Is there ever any mucous in your stools? ……

Does stress affect your bowel movements? ……

Do you crave any particular type of food and if so what? ……..

Do you smoke? …….. If yes, how many a day? ……

Do you drink alcohol? …… If yes, how many units per week? …….

How many cups of tea and/or coffee do you drink a day? ……..

Do you add sugar and if so, how much? …….

Do you drink soft drinks (cola etc.) and if so, how many? ……

How many glasses of water do you drink each day? ……..

How often do you exercise? ……

How many hours sleep do you need/get? ……...

Do you have a good appetite? ……

Do you suffer from any food allergies/food sensitivities? ……..

If yes, please list ……..

……..

Do you frequently travel abroad? ……...

If yes, have you ever suffered with sickness and/or diarrhoea? …….

Are you under a lot of stress at the moment? ……..

If yes, do you know the cause of it? ……

Please tick if you suffer, or have suffered from any of the following conditions:

General

Alcoholism ……
Amalgam fillings-how many ……
Anaemia ……
Cancer (of any type) ……
Chronic Fatigue Syndrome ……
Diabetes ……
Dizziness ……
Double/blurred vision ……
Drug addiction ……
Fainting spells ……
Ear infections ……
Epilepsy ……
Headaches/Migraines ……
Hepatitis ……
HIV/Aids ……
Hypoglycaemia ……
M.E. ……
Weight loss ……
Over-active thyroid gland ……
Under-active thyroid gland ……
Gallstones ……

Gastro-intestinal

Abdominal pain ……
Bad breath ……
Colitis ……
Constipation ……
Cravings ……
Diarrhoea ……
Distension/abdominal bloating ……
Diverticulitis/Diverticulosis ……
Hearburn ……
Indigestion ……
Irritable Bowel Syndrome ……
Liver trouble (e.g. fatty liver) ……
Rectal bleeding ……
Rectal itching ……
Ulcerative Colitis ……

Cardio-vascular

Angina/Chest pain ……
Hardening of the arteries ……
Low blood pressure ……
Rapid irregular heart beat ……
Swelling of the ankles ……

Muscle and joint

Arthritis ……
Low back pain ……
Joint pain/stiffness ……
Rheumatism ……
Muscle weakness ……

Emotional/nervous system

Anxiety ……

Skin

Acne ……

Depression ……
Fatigue ……
Insomnia ……
Irritability ……
Lack of concentration ……
Lethargy ……
Mood swings ……
Over-reacting ……
Panic attacks ……
Memory loss ……

Bruise easily ……
Dermatitis ……
Eczema ……
Fungal infections ……
Psoriasis ……

Respiratory

Asthma ……
Bronchitis ……
Emphysema ……
Hayfever ……
Sinus problems ……

Women

Amenorrhoea (absence of periods) ……
Dysmenorrhoea (painful periods) ……
Endometriosis ……
Genital herpes ……
Genital warts ……
Heavy menstrual flow ……
Hysterectomy ……
PMT ……
Vaginal thrush ……
Are you pregnant? ……
Date of last period ……
Are you on the Pill? ……

Genito-urinary

Bladder infections ……
Kidney infections/stones ……

Men

Enlarged prostate ……
Genital herpes ……
Genital warts ……

Daily diet – please give an indication of a typical daily diet

Breakfast …….

Mid-morning ……

Lunch ……

Mid-afternoon ……..

Dinner ……..

Have you ever suffered from anorexia or bulimia? …….

Do you ever over-eat? …….

Are you vegetarian or vegan or neither? ……

Do you feel that certain foods upset you and if so, which? ……

Please give any other information you may think is relevant ……

…….

List your main reasons for wanting Colon Hydrotherapy

…….

…….

…….

The information provided above is, to the best of my knowledge, true and accurate

Signed …….. Date …….

I agree to having a rectal examination if during discussion it is deemed necessary

Signed …… Date ……..