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Vitality Colonics

Colon Hydrotherapy Questionnaire - Please fill this questionnaire and bring it with you to your treatment.

Surname:	E-Mail:	
Name:	Telephone No:	
Address:		
	Date of Birth:	Sex: M/F
Have you had colonics before: Y N		

Occupation _____

Where did you hear about us? _____

GP's Name and Address _____

_____

Please answer the following as accurately as possible:

Are you seeing your Doctor at present? YES/NO (If Yes, please give details) _____

_____

List any medications, supplements you are taking: _____

_____

List any medical conditions you have _____

_____

List any surgical procedures you have had and the dates _____

_____

List any allergies you may have _____

Do you suffer from any of the following

- ☐ Hernia
- ☐ Cancer of the colon or rectum
- ☐ Colitis
- ☐ Ulcerative Colitis
- ☐ Crohn's
- ☐ Congestive heart disease
- ☐ Diverticulitis
- ☐ Fistula
- ☐ Fissure
- ☐ Hirschsprung's disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Inflamed haemorrhoids
- ☐ Rectal bleeding
- ☐ Radiotherapy of abdominal area not discharged from medical care
- ☐ Severe Anaemia
- ☐ Renal insufficiency
- ☐ Severe persistent diarrhoea
- ☐ Diabetes

Have you ever had surgery of colon or rectum?	YES/NO	If yes, when_____
Have you ever had a bowel biopsy	YES/NO	If yes, when_____
Have you had abdominal surgery e.g. hysterectomy/laparoscopy	YES/NO	If, yes when_____
Are you undergoing chemo-therapy and cancer treatments?	YES/NO	
Do you take oral or rectal steroids?	YES/NO	
Are you pregnant?	YES/NO	
Are you breastfeeding?	YES/NO	
Do you smoke?	YES/NO	How many a day?_____
Do you drink alcohol?	YES/NO	How much a week?_____

How many glasses of water do you drink a day? _____

Do you follow a specific diet? Eg vegan, gluten free YES / NO Please describe _____

Please describe a typical days food _____

_____

General Bowel Movements

Do you require laxatives? YES / NO If yes, what do you take? _____

How would you describe your bowel movements? Please tick where appropriate

Less than once a week Once a day After eating Occasional Twice a day Require straining

Frequency - every _____ days

Do you suffer from any of the following? Please tick where appropriate

Diarrhoea Constipation Gas/Wind Bloating

Main reasons for your visit today _____

Declaration

I agree to undergo a colon hydrotherapy treatment from Tracie Somerset

Name _____

Signed _____

Date _____

Colon Hydrotherapy is a safe and effectively cleanses your large intestine/colon. Your Therapist does not diagnose disease or prescribe medications. Should any of your responses to any of the above questions contraindicate colon hydrotherapy you will be advised to seek your doctor's help. It is responsibility to provide full and complete answers so your Therapist can treat you correctly. Also you must inform us of any changes to your health between treatments.

General Data Protection Regulations (GDPR)

I am happy to receive any information on promotions and/or newsletter. YES/NO

I consent to being contacted by EMAIL YES/NO TEXT- YES/NO