Brief Interlude **Integrated Health Therapies - Est'd 1996**
Normandy Practice - Willow Cottage, 115 Glaziers lane
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Colon Hydrotherapy Questionnaire

All information provided in this questionnaire will be treated in the strictest confidence.

Full Name: ....

Address: ....

Telephone: (Mob) .... (Home) .... (Work) ....

Date of Birth: .... Age: .... Gender:.............................. Height:............................ Weight:..........................

Occupation: .... Email: .... @ ....

Marital Status: Single/Married/Partner/Separated/Divorced/Widowed Do you have any children? ....

Currently receiving any medical treatment? YES / NO Details: ....

....

....

Past medical issues /procedures with approx dates: ....

....

....

....

List any medication/vitamin/mineral/herbal supplements: ....

....

....

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

....

Do you suffer from, or have you ever suffered from:-

High blood pressure .... YES / NO
Heart disease.. YES / NO
Severe Haemorrhoids .... YES / NO
Abdominal or Inguinal Hernia................ YES / NO
G.I. Haemorrhage / Perforation........... YES / NO
Fissures / Fistulas .... YES / NO

Kidney failure .... YES / NO
Cirrhosis of the liver .... YES / NO
Cancer of the Colon or Rectum .... YES / NO
Recent colon or rectal surgery.............. YES / NO
Severe Anaemia .... YES / NO

Allergies: Are you allergic to Latex .... YES / NO Any other allergies? ....

Additional Information

Please give any other relevant information: ....

....

....

Main reason for wanting Colon Hydrotherapy: ....

Recommended by / saw advertisement: ....

The information provided above is, to the best of my knowledge, true and accurate. The procedure for Colon Hydrotherapy has been explained and I hereby give my consent for a digital examination and Colon Hydrotherapy to be performed on myself.

Signature: .... Date: ....

Please **CIRCLE** –

C *if you Currently suffer, or*
P *if you have suffered in the Past, or*
P & C *if both in the past & currently suffer*

from any of the following conditions:

General

Alcoholism	P	C
Anaemia	P	C
Anorexia or Bulimia	P	C
Cancer (of any type)	P	C
Chronic Fatigue Syndrome	P	C
Diabetes	P	C
Dizziness	P	C
Double/blurred vision	P	C
Drug Addiction	P	C
Fainting Spells	P	C
Ear Infections	P	C
Epilepsy	P	C
Headaches/Migraine	P	C
Hepatitis	P	C
HIV/Aids	P	C
Hypoglycaemia	P	C
M.E.	P	C
Loss of weight	P	C
Over active thyroid gland	P	C
Recreational Drugs	P	C
Under active thyroid gland	P	C

Cardiovascular

Angina (Chest pain)	P	C
Hardening of the arteries	P	C
Low blood pressure	P	C
Rapid/irregular heart beat	P	C
Swelling of ankles	P	C

Emotional/Nervous System

Anxiety	P	C
Depression	P	C
Fatigue	P	C
Insomnia	P	C
Irritability	P	C
Lack of Concentration	P	C
Lethargy	P	C
Mood Swings	P	C
Nervous exhaustion	P	C
Overeating	P	C
Panic attacks	P	C
Poor Memory	P	C

Gastro-Intestinal

Abdominal pain	P	C
Bad breath	P	C
Colitis	P	C
Constipation	P	C
Diarrhoea	P	C
Distension & bloating of abdomen	P	C
Diverticulitis / Diverticulosis	P	C
Excessive Flatulence	P	C
Gall bladder disease	P	C
Heartburn	P	C
Indigestion	P	C
Irritable bowel syndrome	P	C
Liver trouble	P	C
Rectal bleeding	P	C
Rectal itching	P	C
Ulcerative Colitis	P	C
Vomiting of blood	P	C

Genito-Urinary

Bladder infections	P	C
Kidney infections/stone	P	C
Painful urination	P	C
Recurring cystitis	P	C

Muscle and Joint

Arthritis	P	C
Low back pain	P	C
Joint pain/stiffness	P	C
Multiple Sclerosis	P	C
Swollen joints	P	C

Respiratory

Asthma / Bronchitis	P	C
Emphysema	P	C
Hay fever	P	C
Shortness of breath	P	C
Sinus problems	P	C
Tuberculosis	P	C

Skin

Acne	P	C
Bruise Easily	P	C
Dermatitis	P	C
Dryness	P	C
Eczema	P	C
Fungal infections	P	C
Itching	P	C
Psoriasis	P	C

Women

Amenorrhoea (absence of periods)	P	C
Dysmenorrhoea (painful periods)	P	C
Endometriosis	P	C
Genital Herpes or Warts	P	C
Heavy menstrual flow	P	C
Hysterectomy	P	C
Infertility	P	C
Miscarriage	P	C
PMT	P	C
Prolapsed womb	P	C
Vaginal Thrush	P	C

Are you pregnant?..YES / NO

If yes, how many weeks? ....

Date of last menstrual period: ....

Do you take the contraceptive pill or HRT?.............YES / NO

Do you use an I.U.D.? ....YES / NO

Men

Enlarged Prostate	P	C
Genital Herpes	P	C
Genital Warts	P	C
Impotence	P	C
Low sperm count/motility	P	C

Practitioners Record

Date	/ /	/ /	/ /	/ /	/ /	/ /
Abdominal Distension	No Yes Above Below Both	No Yes Above Below Both	No Yes Above Below Both	No Yes Above Below Both	No Yes Above Below Both	No Yes Above Below Both
Pain on examination	No Yes Low Dec SpFlx Trnsv	No Yes Low Dec SpFlx Trnsv	No Yes Low Dec SpFlx Trnsv	No Yes Low Dec SpFlx Trnsv	No Yes Low Dec SpFlx Trnsv	No Yes Low Dec SpFlx Trnsv
Scope	L E N T Fwd Dwn Short	L E N T Fwd Dwn Short	L E N T Fwd Dwn Short	L E N T Fwd Dwn Short	L E N T Fwd Dwn Short	L E N T Fwd Dwn Short
BM History	Rg I-rg Multi 1 2 3	Rg I-rg Multi 1 2 3	Rg I-rg Multi 1 2 3	Rg I-rg Multi 1 2 3	Rg I-rg Multi 1 2 3	Rg I-rg Multi 1 2 3
BM Today / Recent	Today Prev 1 2 3 4 5	Today Prev 1 2 3 4 5	Today Prev 1 2 3 4 5	Today Prev 1 2 3 4 5	Today Prev 1 2 3 4 5	Today Prev 1 2 3 4 5
Comfort	WW SS MS VS Lkg Sml Lg H	WW SS MS VS Lkg Sml Lg H	WW SS MS VS Lkg Sml Lg H	WW SS MS VS Lkg Sml Lg H	WW SS MS VS Lkg Sml Lg H	WW SS MS VS Lkg Sml Lg H
Released	S M L H Dec SpFlx Trnsv Asc	S M L H Dec SpFlx Trnsv Asc	S M L H Dec SpFlx Trnsv Asc	S M L H Dec SpFlx Trnsv Asc	S M L H Dec SpFlx Trnsv Asc	S M L H Dec SpFlx Trnsv Asc
Consistency	Clr Col Bt S Flk Sft Hd RndBls VHd	Clr Col Bt S Flk Sft Hd RndBls VHd	Clr Col Bt S Flk Sft Hd RndBls VHd	Clr Col Bt S Flk Sft Hd RndBls VHd	Clr Col Bt S Flk Sft Hd RndBls VHd	Clr Col Bt S Flk Sft Hd RndBls VHd
Colour	P M D VD Y O G B	P M D VD Y O G B	P M D VD Y O G B	P M D VD Y O G B	P M D VD Y O G B	P M D VD Y O G B
Post Treatment	W S Pt Mxd Lg Sm	W S Pt Mxd Lg Sm	W S Pt Mxd Lg Sm	W S Pt Mxd Lg Sm	W S Pt Mxd Lg Sm	W S Pt Mxd Lg Sm
Undigested food	No Yes Chk?	No Yes Chk?	No Yes Chk?	No Yes Chk?	No Yes Chk?	No Yes Chk?
Mucous	No Yes Old New	No Yes Old New	No Yes Old New	No Yes Old New	No Yes Old New	No Yes Old New
Gas	No Yes Wr S M L	No Yes Wr S M L	No Yes Wr S M L	No Yes Wr S M L	No Yes Wr S M L	No Yes Wr S M L
Candida	No Yes Old New Chk?	No Yes Old New Chk?	No Yes Old New Chk?	No Yes Old New Chk?	No Yes Old New Chk?	No Yes Old New Chk?
Supplements	Fa Fb Fc F2 Bio-Ac SpG Flx Rec Tkn Cont	Fa Fb Fc F2 Bio-Ac SpG Flx Rec Tkn Cont	Fa Fb Fc F2 Bio-Ac SpG Flx Rec Tkn Cont	Fa Fb Fc F2 Bio-Ac SpG Flx Rec Tkn Cont	Fa Fb Fc F2 Bio-Ac SpG Flx Rec Tkn Cont	Fa Fb Fc F2 Bio-Ac SpG Flx Rec Tkn Cont
Acidophilus	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

Notes: ....

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