Gedling Colonics

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HEALTH QUESTIONNAIRE

(In strictest confidence)

Please save this document, complete, save and return to us by email or post. Alternatively bring the completed form with you to your appointment.
If you have any problems please contact jane@gedlingcolonics.co.uk

Full name (including title) ……..

Address (including postcode) …….

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

e-mail address (e-mail address for communication purposes and from time to time, Gedling Colonics send out health tips)
…….

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? ……..

If ‘yes’, what were they prescribed for? ……

Are you, or have you, in the past, taken recreational Drugs? If ‘yes’, please give details …….

..……..……

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

'Do you have any pets - cats, dogs etc? ……..

Current health complaints and duration …..……...

……..

Are you consulting your GP or a Hospital Specialist regarding your health? ……

If so, what for?…….

……..

Please list any prescribed medications you are taking ……

……..

Do you/have you ever taken any steroid based medication?……...

If so, what for and what was the duration?..... ……

……..

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

……..

List all surgical procedures in the last two years ……

…….

Have you ever been hospitalised, either as a baby, child or adult for an infection that required the prescribing of antibiotics, particularly intra-venous antibiotics? If so, what for, when, and the duration of your stay in hospital?

……
……

Were you born by caesarean or was it a natural birth?
……

Were you breast fed or bottle fed? ……

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 or kidney problems ……..

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 …… Any bleeding from the rectum …….

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

……..

Have you ever had any of the following procedures?:

Colonoscopy……. Sigmoidoscopy……..

Barium Enema…… Scans of the Abdominal area.……

Gastroscopy (sometimes referred to as Endoscopy - camera down the throat) .....

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

……..

Do you, or have you in the past ever administered rectal enemas? ……

Have you had colonic hydrotherapy before? If so, with whom, and when ……...

……..

Any family health conditions ……..

……..

Has a close family member (parents, grandparents, brother, sister) been diagnosed with bowel cancer, crohn's disease, coeliac disease, colitis, diverticulitis? If so, please give details

……..

……..

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? ……

Have you ever smoked? If so, when did you stop .....

and how many cigarettes were you smoking each 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	……
Heartburn	……
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	……
Depression	……
Fatigue	……

Skin

Acne	……
Bruise easily	……
Dermatitis	……

Insomnia	……	Eczema	……
Irritability	……	Fungal infections	……
Lack of concentration	……	Psoriasis	……
Lethargy	……		
Mood swings	……		
Over-reacting	……		
Panic attacks	……		
Memory loss	……		

Respiratory

Asthma	……
Bronchitis	……
Emphysema	……
Hayfever	……
Sinus problems	
C.O.P.D	……

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 ……

…….

What do you think needs to change to improve your health? .....

.....

List your main reasons for wanting Colon Hydrotherapy

…….

…….

…….

How did you hear about Jane and Gedling Colonics? (recommended/website/google etc.)

…….

The information provided above is, to the best of my knowledge, true and accurate. I also confirm that I have not with-held any health/personal information that may affect the therapist's decision to treat me with colon hydrotherapy.

Signed …….. Date …….

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

Signed …… Date ……..

If suffering from diabetes, angina, heart disease, or epilepsy, in the event of an attack, I agree to the following action being taken: (delete as appropriate): administer my medication/call an ambulance/call relative/position comfortably.

Signed ..... Date .....