West London Colonics new client intake questionnaire

Please complete this questionnaire (either typed or by hand), *print it out,* and bring it with you to your initial colon hydrotherapy session with WLC.

Colon hydrotherapy (or colonics) is an adjunct holistic approach to health, not a medical procedure. The purpose of this questionnaire is to aid in the consultation that forms part of the first session, and determine your objectives in having colonics.

Name …………………………………………………………………………………. Date ………………………….

Address…….

Postcode ……………………………………………… Email………………………………………………………

Tel: Home ……………………………………………. Mobile ……………………………………………………….

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

Occupation …………………………………………. Marital status ……………………………………………..

How did you hear about West London Colonics? ………………………………………………………………………

Have you had colon hydrotherapy treatments before? ……………………………………………………………….

If so, when and where? …………………………………………………………………………………………………..

Name & address of GP………………………………………………………………………………………………...

………

How many children? ……………… Describe your current health………………………………………………....

What is your reason for treatment? ………………………………………………………………………………...

Please list all medications you take…………………………………………………………………………………..

………

List past surgical procedures & dates……………………………………………………………………………….

………

List any supplements you take………………………………………………………………………………………..

………

List any alternative treatments you are receiving…………………………………………………………………....

Please circle any that are appropriate. My bowel movements (BMs) are:

Spontaneous Occur after eating, Effortless Require straining/Painful Incomplete feeling

How regular are your bowel movements (BMs)? Please circle any that are appropriate.

Once daily 2 / 3 times daily Every 2 days Every 3 /4 days 5 days or more

What do your stools look like? Please circle any that are appropriate

Fat Sausage Skinny Sausage Rabbit droppings Pebbles Loose Diarrhea

Do you stools mainly float or sink?……………………… Are your stools smelly? YES / NO / SOMETIMES

How long have you had from the above pattern of bowel movements?…………………………………………

Is there mucous in your stools? YES / NO

Does stress affect your bowel movements YES / NO

Have you taken antibiotics in the past? If yes how often?…………………………………………………………

Is there a family history of intestinal problems? YES/NO If yes, what? …………………………………………

Have you had a barium enema, colonoscopy? YES/NO

If YES, when? And what were the results? ……………………………………………………………………………

Which best describes the condition of your skin? Dry / Combination / Sensitive / Oily/ Dehydrated

Describe the condition of your nails………………………… Describe the condition of your hair………………

Health conditions summary list
Please circle any conditions that you currently have **('N')** or have experienced.in the past **('P')**
['N' = now & 'P' = past condition]. If the condition is current, indicate how long its been present.

Digestive conditions

Fatigue after eating N / P
Craving N / P
Lactose intolerance N / P
Indigestion N / P
Gas / bloating N / P
Reflux / heartburn N / P
Constipation N / P
Diarrhoea N / P
Atonic colon N / P
Gripping / cramps N / P
Black stools N / P
Rectal bleeding N / P
Ulcerative colitis N / P
Parasite infection N / P
Spastic colon N / P
IBS N / P
Crohn's disease N / P
Anal itching / burning N / P
Ulcers N / P
Perforation N / P
Fissure / fistula N / P
Hemorrhoids N / P
Abdominal pain N / P
Bad breath N / P
Diverticulitis N / P
Excessive flatulence N / P
Gall bladder disease N / P
Liver problems N / P
Vomiting of blood N / P
Candida N / P

Other conditions

Severe cardiac disease N / P
High blood pressure N / P
Severe anemia N / P
Kidney problems N / P
Rectal surgery N / P
Prostate problems N / P
Cancer N / P
Diabetes N / P
Asthma N / P
Chronic fatigue syndrome N / P
Dizziness N / P
Alcoholism N / P
Drug addition N / P
Ear infections N / P
Epilepsy N / P
Migraine N / P
Hepatitis N / P
M.E. N / P
Thyroid problems N / P
Arthritis N / P
Low back pain N / P
Multiple sclerosis N / P
Swollen joints N / P
Hay fever N / P
Sinus problems N / P
Acne N / P
Bruise easily N / P
Eczema N / P
Fungal infections N / P
Psoriasis N / P
Bronchitis N / P
HIV N / P
Varicose veins N / P
STD N / P
Cold hands and feet N / P
Water retention N / P
Eating disorder N / P

Nervous system

Anxiety N / P
Depression N / P
Fatigue N / P
Insomnia N / P
Irritability N / P
Lack of concentration N /P
Mood swings N / P
Nervous breakdown N / P
Overeating N / P
Panic attacks N / P
Schizophrenia N / P
Headaches N / P

Women's issues

Absence of periods N / P	Painful periods N / P	Endometriosis N / P
Heavy menstrual flow N / P	Hysterectomy N / P	Infertility N / P
Miscarriage N / P	PMT N / P	Prolapsed womb N / P
Vaginal thrush N / P	HRT N / P	Contraceptive pill N / P
Irregular periods N / P		

Lifestyle & diet factors

Do you smoke? If yes how many per day? ……………………………………………

Do you drink alcohol? If yes how much per day? ………………………………………

Do you drink tea/coffee/cola? If yes how much per day? ………………………………………

If yes, are these drinks caffeinated? YES/NO Do you chew your food well? Yes / NO

Which best describes your urine? (Please circle as appropriate)

Clear Very pale Yellow Dark yellow Orange Smelly

How much water / herb teas / squash do you drink a day? ………………………………………. Litres/glasses

Do you exercise? How often? ………………………………………………………………

Do you take drugs or substances? If yes, what?
…………………………………………………………

Do you suffer from allergies/food sensitivities? OR Do any foods make you feel bloated or tired?

If yes, please list these……………………………………………………………………………………………………

………

Do you frequently travel abroad? YES/NO

Have you been treated for stomach upset / diarrhea / parasites after traveling abroad?
YES/NO

If yes, what was the treatment for? And have the symptoms stopped?…………………………………………

………

Are you under a lot of stress? YES/NO

How do you relax or manage stress? ………………………………………………………………………………

……..

What is your quality of sleep?......
Please give an indication of a typical daily diet

Breakfast ………

Mid morning ……

Lunch ……

Mid afternoon ………………………………………………………………………………………………………

Dinner ………

Are you vegetarian or vegan? YES / NO / NEITHER

Have you ever suffered from Anorexia or Bulimia? YES / NO
Please give **any other information** that you think is relevant

Contraindications
If you have been diagnosed with any of the following complaints, colon Hydrotherapy treatment would not be suitable for you :

Abdominal hernia
Aneurysm
Blood clots
Cirrhosis of the liver
Congestive cardiac failure
Colon, kidney or liver cancer
Crohn's disease
Diverticulitis (inflamed, medicated , symptomatic)
Pregnancy (some stages of)
Recent colon or rectal surgery

Rectal bleeding
Rectal fissures
Renal insufficiency
Severe anaemia
Severe cardiac disease
Severe haemorrhoids
Severe prostate problems
Ulcerative colitis
Uncontrolled high blood pressure
long term steroid medications

Context for treatment
Colon hydrotherapy is not intended to replace the relationship with your primary health care providers. Julia Rhodes, our professionally certified colon hydro therapist is not medically qualified, although she is a (non) practising physiotherapist. Any knowledge, information, insights shared are from education, research, and experience in the field of holistic health, not the field of medicine. Neither the information shared, nor the service provided seeks to prescribe, recommend, diagnose or treat disease conditions. If you have (or suspect you may have) a health problem needing medical attention, please consult with your doctor (s).

Consent declaration
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 necessary) administer my medication / call ambulance / call relative / discontinue treatment / position comfortably. I confirm I have seen the list of contraindicated conditions and confirm the absence of any active or current contra-indicated conditions.
I agree to a rectal examination (in the event this is deemed necessary by the therapist) and to a colon hydrotherapy treatment as described by the therapist. I confirm that this form has been completed based on true and accurate information I have provided.

Client signature ……………………………………………………… **Date** ………………………

Therapist signature …………………………………………………… **Date** ……………………