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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

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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?
Perforation | Severe anaemia |
| Fissures/Fistulas | |

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..... |

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?

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

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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

Gastro-intestinal

Abdominal pain
 Bad breath
 Colitis
 Constipation
 Cravings
 Diarrhoea
 Distension/abdominal bloating
 Diverticulitis/Diverticulosis

Drug addiction	.....	Heartburn	.....
Fainting spells	.....	Indigestion	.....
Ear infections	.....	Irritable Bowel Syndrome	.....
Epilepsy	.....	Liver trouble (e.g. fatty liver)	.....
Headaches/Migraines	.....	Rectal bleeding	.....
Hepatitis	.....	Rectal itching	.....
HIV/Aids	.....	Ulcerative Colitis	.....
Hypoglycaemia	.....	
M.E.	.....	
Weight loss	.....	
Over-active thyroid gland	.....	
Under-active thyroid gland	.....	
Gallstones	.....	

Cardio-vascular

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

Emotional/nervous system

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

Respiratory

Asthma	.....
Bronchitis	.....
Emphysema	.....
Hayfever	.....
Sinus problems	.....

Muscle and joint

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

Skin

Acne	.....
Bruise easily	.....
Dermatitis	.....
Eczema	.....
Fungal infections	.....
Psoriasis	.....

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

Men

Bladder infections	.....	Enlarged prostate	.....
Kidney infections/stones	.....	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

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List your main reasons for wanting Colon Hydrotherapy

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How did you hear about Linda? (recommended/website/google etc)

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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