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HEALTH QUESTIONNAIRE

(In strictest confidence)

**Please save this document to your PC, complete, save and send.
If you have any problems contact: lindabooth@btinternet.com**

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, to receive marketing emails from Linda and Just For Tummies)
.....

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

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

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

Current health complaints, and duration

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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, including asthma inhalers?

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

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List all past medical problems with approximate dates

.....

List all surgical procedures

.....

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?

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Were you born by cesarian 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

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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
- 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

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

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

Muscle and joint

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

Skin

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

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

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

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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

'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