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### Colon Hydrotherapy Questionnaire

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

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_ E-Mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_

Name and Address of G.P. \_\_\_\_\_

Do I have your consent to contact your GP if necessary? YES/NO

Marital Status: Single/Married/Divorced/Separated/Widowed How many children do you have? \_\_\_\_\_

Current Health Complaints: \_\_\_\_\_

Please list all medications you are taking: \_\_\_\_\_

List all past medical problems with approximate dates: \_\_\_\_\_

List all past surgical procedures with approximate dates: \_\_\_\_\_

List any vitamin/mineral/herbal/homeopathic supplements you are taking: \_\_\_\_\_

Are the above prescribed or self-prescribed? \_\_\_\_\_ How long have you been taking supplements? \_\_\_\_\_

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

Have you received any antibiotic treatment in the past two years? YES/NO

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

High blood pressure	YES/NO	Kidney disease/failure	YES/NO
Heart Disease	YES/NO	Cirrhosis of the liver	YES/NO
Severe Haemorrhoids	YES/NO	Cancer of the Colon or Rectum	YES/NO
Abdominal or Inguinal Hernia	YES/NO	Recent Colon or Rectal surgery	YES/NO
G.I. Haemorrhage/Perforation	YES/NO	Severe Anaemia	YES/NO
Fissures/Fistulas	YES/NO		

If you answered YES to any of the above, please give details: \_\_\_\_\_

<p>Please tick if you suffer, or have suffered, from any of the following conditions:</p>					
<p><b>General</b></p>		<p><b>Gastro-Intestinal</b></p>		<p><b>Skin</b></p>	
Alcoholism	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Acne	<input type="checkbox"/>
Amalgam Fillings – How many?	<input type="checkbox"/>	Bad breath	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>
Anaemia	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	Dermatitis	<input type="checkbox"/>
Cancer (of any type)	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Dryness	<input type="checkbox"/>
Chronic Fatigue Syndrome	<input type="checkbox"/>	Craving	<input type="checkbox"/>	Eczema	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Diarrhoea	<input type="checkbox"/>	Fungal infections	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	Distension & bloating of abdomen	<input type="checkbox"/>	Itching	<input type="checkbox"/>
Double/blurred vision	<input type="checkbox"/>	Diverticulitis/Diverticulosis	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	Excessive Flatulence	<input type="checkbox"/>		
Fainting Spells	<input type="checkbox"/>	Gall bladder disease	<input type="checkbox"/>	<b>Women</b>	
Ear Infections	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Amenorrhoea (absence of periods)	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	Dysmenorrhoea (painful periods)	<input type="checkbox"/>
Headaches/Migraine	<input type="checkbox"/>	Irritable bowel syndrome	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	Liver trouble	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>
HIV/Aids	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	Genital Warts	<input type="checkbox"/>
Hypoglycaemia	<input type="checkbox"/>	Rectal itching	<input type="checkbox"/>	Heavy menstrual flow	<input type="checkbox"/>
M.E.	<input type="checkbox"/>	Ulcerative Colitis	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>
Loss of weight	<input type="checkbox"/>	Vomiting of blood	<input type="checkbox"/>	Infertility	<input type="checkbox"/>
Over active thyroid gland	<input type="checkbox"/>	Do you use laxatives	YES/NO	Miscarriage	<input type="checkbox"/>
Under active thyroid gland	<input type="checkbox"/>			PMT	<input type="checkbox"/>
		<b>Genito-Urinary</b>		Prolapsed womb	<input type="checkbox"/>
		Bladder infections	<input type="checkbox"/>	Scant menstrual flow	<input type="checkbox"/>
		Kidney infections/stone	<input type="checkbox"/>	Too frequent periods	<input type="checkbox"/>
		Painful urination	<input type="checkbox"/>	Vaginal Thrush	<input type="checkbox"/>
		Recurring cystitis	<input type="checkbox"/>		
<b>Cardiovascular</b>				Are you pregnant?	YES/NO
Angina (Chest pain)	<input type="checkbox"/>	<b>Muscle and Joint</b>		If yes, how many weeks?	_____
Low blood pressure	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Date of last menstrual period:	_____
Rapid/irregular heart beat	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	Do you take the contraceptive pill or HRT?	YES/NO
Swelling of ankles	<input type="checkbox"/>	Joint pain/stiffness	<input type="checkbox"/>	Do you use an I.U.D.?	YES/NO
		Multiple Sclerosis	<input type="checkbox"/>		
<b>Emotional/Nervous System</b>		Muscle weakness	<input type="checkbox"/>		
Anxiety	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>		
Depression	<input type="checkbox"/>			<b>Men</b>	
Fatigue	<input type="checkbox"/>	<b>Respiratory</b>		Enlarged Prostate	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Genital Warts	<input type="checkbox"/>
Lack of Concentration	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Impotence	<input type="checkbox"/>
Lethargy	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>		
Mood Swings	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>		
Nervous breakdown	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>		
Nervous exhaustion	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>		
Overeating	<input type="checkbox"/>				
Panic attacks	<input type="checkbox"/>				
Poor Memory	<input type="checkbox"/>				
Schizophrenia	<input type="checkbox"/>				

Do you have a family history of any of the following conditions?

Crohn's Disease	YES/NO
Ulcerative Colitis	YES/NO
Heart Disease	YES/NO
Cancer	YES/NO
Diabetes	YES/NO
Asthma	YES/NO

If you answered YES to any of the above, please give details: \_\_\_\_\_

Do you smoke?	YES/NO	How many? _____
Do you drink alcohol?	YES/NO	How much? _____
Do you drink Coffee?	YES/NO	How many cups per day? _____
Do you drink tea?	YES/NO	How many cups per day? _____
Do you drink soft drinks (cola etc.)?	YES/NO	How many glasses per day? _____
Do you drink water?	YES/NO	How many glasses per day? _____
Do you exercise?	YES/NO	How often? _____
Do you take recreational drugs?	YES/NO	How often and what type? _____

How regular are your bowel movements? \_\_\_\_\_

Describe the colour, smell and shape of your stool: \_\_\_\_\_

How many hours sleep do you need/get? \_\_\_\_\_

Do you have a good appetite? YES/NO

Do you suffer from any allergies/food sensitivities? YES/NO

If you answered YES to the above question, please list them: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you frequently travel abroad? YES/NO

Are you under a lot of stress? YES/NO

### Daily Diet

**Please provide an indication of your typical daily diet**

Breakfast: \_\_\_\_\_

Mid Morning: \_\_\_\_\_

Lunch: \_\_\_\_\_

Mid Afternoon: \_\_\_\_\_

Dinner: \_\_\_\_\_

Have you ever suffered from Anorexia or Bulimia? YES/NO

Are you a Vegetarian or Vegan? VEGETARIAN/VEGAN/NEITHER

### Additional Information

Please provide any other information which you think may be relevant: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Main reasons 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/my child

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

