

## CLIENT QUESTIONNAIRE AND CONSENT FORM

- If you cannot fit your answers in the space provided, please add a continuation sheet and cross reference the responses.
- Please list all your known medical conditions, even if they are not covered in the questionnaire. Some answers overlap others, you do not have to repeat any answers.
- Your records will be locked away securely. The date will not be divulged to any third party without your written permission. Strict confidentiality will be maintained.
- The reasons for the questions are multiple. Firstly, we need to know if you have any contraindications for colon hydrotherapy. Secondly, we wish to give as holistic a service as possible. However, if you do not wish to answer any questions, please leave blank.

Name:	DoB:	Age:
Address:		
Profession:	Married/Single	Male/Female
Number and ages of children:		
Tel No: (H)	(M)	(W)
Preference of phone contact:		
Email address:		
GP name and address:		
Pregnant	Yes/No	If yes, how many weeks:
Describe any previous pregnancies:		
Describe any surgery and when:		

**Do you have, or have ever had, any diseases/dysfunctions of the following (please circle answer):**

Liver	Yes/No	Gall bladder	Yes/No
Kidney	Yes/No	Pancreas	Yes/No
Urinary tract	Yes/No	Hormones	Yes/No
Prostate	Yes/No	Lungs	Yes/No

**Do you have, or have ever had, a history of the following (please circle answer):**

Diabetes	Yes/No	Severe anemia	Yes/No
Cysts/tumours	Yes/No	Ulcers	Yes/No
Arthritis	Yes/No	Swollen glands	Yes/No
Back pain	Yes/No	Herpes	Yes/No
Mental, psychological/emotional problems	Yes/No	Other	

Do you have any known allergies and/or intolerances (food – which and what symptoms, latex, asthma, other). If yes, give details:	Yes/No
Do you, or have you, ever smoked. If yes, give details:	Yes/No
Do you, or have you, taken any drugs or substances. If yes, give details:	Yes/No
Do you, or have you, had a problem with alcohol	Yes/No
How would you describe your skin – dry, oily, combination, sensitive, dehydrated (please circle)	
How would you describe the condition of your hair:	
How would you describe the condition of your nails:	
Do you, or have you, had any eating disorders (even just comfort eating)	Yes/No
Do you eat in a hurry	Yes/No
Do you chew your food well	Yes/No
Describe your profession: sedentary/physically active, stressful/enjoyable (please circle). How is the environment:	
Do you exercise and how often:	
Describe your sleep pattern:	
Are there any aspects of your life you are not happy with?	
List all medications and/or supplements you are taking:	
Have you ever had: barium enema, sigmoidoscopy or colonoscopy? If so, when and what were the results:	

**Please indicate if any of the following that have been issue for you:**

Bloating	Yes/No	Constipation	Yes/No
Colitis	Yes/No	Colon cancer	Yes/No
Diarrhoea	Yes/No	Diverticulosis/diverticulitis	Yes/No
Fissures	Yes/No	Fistulas	Yes/No
Flatulence	Yes/No	Irritable bowel syndrome	Yes/No
Haemorrhoids	Yes/No	Indigestion	Yes/No
Parasites	Yes/No	Intestinal haemorrhage/perforation	Yes/No
Recent surgery	Yes/No	Rectal bleeding	Yes/No

**Females Only:**

Describe your menstruation: regularity, due date, light/heavy, pain, PMT:
Gynaecological details (menopause, HRT, pill, coil etc):

**Immune System:**

Are you prone to infections, sore throats, colds, sinuses etc:
Have you ever taken antibiotics? Yes/No When and for how long:

**Circulation system (indicate all that apply):**

Heart condition	Yes/No	High blood pressure	Yes/No
High cholesterol	Yes/No	Blood clots	Yes/No
Tired legs	Yes/No	Fluid retention	Yes/No
Varicose veins	Yes/No	Other:	

**Nervous system (indicate all that apply):**

Headaches	Yes/No	Migraines	Yes/No
Depression	Yes/No	Stress	Yes/No
How do you relax and/or manage stress:			
How do you manage time and your own personal needs for yourself:			

**Bowel movements:**

How frequently/is there a regular pattern:
Do you have to strain:
Does the stool float or sink:
Is it loose or formed:
Is it soft or hard:
Is the smell strong:
Do you take laxatives and/or other method:

Detail the pattern of your daily fluid intake (litres of water, tea, coffee, fizzy drinks, alcohol etc):	
Are you/have you been on any diets (Atkins, Weight Watchers, Slimfast etc)	Yes/No
Are you a vegetarian. If yes, what type:	Yes/No
How many servings of fruit do you eat each day:	
How many servings of vegetables do you eat each day:	
How many servings of protein do you eat each day, and what type:	
Do you snack between meals and, if so, on what:	
Describe your daily intake of food and drink:	

Any other relevant information not covered in this questionnaire:
Additional space for answers (continue on more paper if you need to):

**NOTE: Regarding Rectal Exam:** A rectal examination (using low allergy latex gloves) has to be carried out before insertion of the colonic tube.

**Consent Declaration:** I wish to have colon hydrotherapy at ParkLand and fully consent to the procedure.

Client's signature: ..... Date: .....