



Private and Confidential

Colonic Hydrotherapy Personal Health Questionnaire

Tel: 0113 258 8700

Web: www.alternativeangels.org

Date of first appointment..... Time.....
 Surname.....
 Forenames.....
 Address.....
 Email Address.....
 Tel No: (Home).....(Work).....(Mobile).....

Age..... Date of Birth...../...../..... Sex.....
 Height..... Weight.....
 Marital Status..... Children.....
 Occupation..... Recommended by

Medical History.

Doctor.....
 Drugs / Medication.....
 Operations/Illnesses/Chronic/Acute.....
 Presenting Problem.....

Do you suffer from...

Allergies		Arthritis/ Rheumatism		Asthma	
Colitis		Constipation		Bad Breath	
Diabetes		Cancer		Diverculitis	
Indigestion		Headaches		Fatigue	
Heart Condition		High Blood Pressure		Thrush	
Ulcers		Haemorrhoids		Candida	
MS		ME		Mucus	
Catarrh		Insomnia		Acne	
Diarrhoea		Rectal Bleeding		Gall Stones	
Dizziness		Liver Trouble		Cirrhosis	
Fissures		Hay Fever		Loss of Weight	
Bronchitis		Double/Blurred Vision		Emphysema	
Poor Circulation		Shortness of Breath		Bruise Easily	
Itching				Swelling of Ankles	

Do you take / have?

Heavy	Moderate	Light	Non
Alcohol			
Coffee			
Tea			
Tobacco			
Drugs			
Exercise			
Sleep			
Appetite			

Do you have bowel movements:

Weekly Every 2/3 days Daily 2/3 Times a day

Do you get colds/flu?..... How often?.....

Do you take vitamins / minerals?.....

Have you ever had a colonic? YES/NO

Contra-indications for colon hydrotherapy.

- Pregnancy
- Severe cardiac disease
- Aneurysm
- Gastro-intestinal haemorrhage or perforation
- Cirrhosis
- Fissure or Fistulas
- Abdominal Hernia
- Renal Insufficiency
- Severe Anaemia
- Severe Haemorrhoids
- Carcinoma of the Colon
- Recent Colon Surgery

I have read and understood the above conditions. I do not have any of the above conditions and therefore agree to have colonic treatments.

Signature of Client:.....

Printed Name:.....

Date.....

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