



Clinic / Practice / Therapist  
Address & details

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**Colonic Irrigation Questionnaire - Please fill this questionnaire and bring it with you to your treatment.**

Surname:	E-Mail:		
Name:	Mobile:		
Address:	Telephone No:		
	Year of Birth:		
	Age:	Sex:	
Have you had colonics before:    Y            N			
What therapies do you use regularly?			

**Reasons for the treatment (tick the ones that apply to you):**

Kick-start healthy living	Irregular bowel movements	Lack of energy	Skin problems
Detox	Constipation	Food cravings	Allergies
Increase energy	IBS/Bloatedness	Mood swings	Parasites
Help with weight loss	Diarrhoea	Yeasts/Candida	Headaches/migraines

**Have these conditions lasted:**    over 1-year    2-3 years    5 years or longer

**Tick the statements that apply to your eating habits and lifestyle:**

I have a balanced diet <input type="checkbox"/>	I don't take dairy <input type="checkbox"/>	I smoke & drink	I snack on sweets/chocolate <input type="checkbox"/>
I drink 8 glasses of water/day <input type="checkbox"/>	I don't eat wheat/gluten <input type="checkbox"/>	I chew thoroughly	I often overeat
I exercise enough <input type="checkbox"/>	I eat salads/vegetables/raw foods	I eat quickly	I have big meals after 8 pm <input type="checkbox"/>
I do not exercise enough <input type="checkbox"/>	I take laxatives <input type="checkbox"/>	I eat ready meals	I often eat bread, pasta etc

**Please state your occupation and describe the levels of stress, a typical workday eating pattern, including meals, snacks and liquid intake. If you smoke or drink alcohol please state how much. If you take recreational drugs please mention this to the practitioner.**

**Describe your typical bowel movements: frequency, amounts and appearance**

**Please check whether you have any of the following conditions for which this treatment is contraindicated:**

- |   |  |   |  |   |
|---|--|---|--|---|
| <input type="checkbox"/> Severe Cardiac Disease | <input type="checkbox"/> Severe Anaemia      | <input type="checkbox"/> Active fissures/fistulae | <input type="checkbox"/> Recent colorectal surgery | <input type="checkbox"/> Cirrhosis or abd. hernia |
| <input type="checkbox"/> Unmonitored High BP    | <input type="checkbox"/> GI haemorrhage/perf | <input type="checkbox"/> Pregnancy                | <input type="checkbox"/> Renal insufficiency       | <input type="checkbox"/> Colorectal carcinoma     |
| <input type="checkbox"/> Crohns                 | <input type="checkbox"/> Diverticulitis      | <input type="checkbox"/> Ulcerative Colitis       |  |   |

**Please check if you have had any of the following:**

- |  |  |  |  |                                    |
|--|--|--|--|------------------------------------|
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Thrush        | <input type="checkbox"/> Bloating  |
| <input type="checkbox"/> Headaches       | <input type="checkbox"/> Other           |  |  |                                    |

Please add any information on operations/surgeries in the last 5 years (continue on the reverse if needed)

Please list any Medications and Nutritional Supplements you take on a daily basis (continue on the reverse if needed):

Signature:

Date:





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**COLONIC THERAPY – OBSERVATION FORM**

Name			
Main concerns			
<b>Treatment 1</b>		<b>Date:</b>	
<b>Description of matter:</b>	Amount	Bloating	Gas
	x xx xxx	x xx xxx	x xx xxx
	Undigested Food	Bowel Tone	On Bristol Stool Scale:
	x xx xxx	x xx xxx	1 2 3 4 5 6
<b>Special Notes</b> (yeasts, parasites, other)			
<b>Update recommendations &amp; supplements</b>			

<b>Treatment 2</b>		<b>Date:</b>	
<b>Description of matter:</b>	Amount	Bloating	Gas
	x xx xxx	x xx xxx	x xx xxx
	Undigested Food	Bowel Tone	On Bristol Stool Scale:
	x xx xxx	x xx xxx	1 2 3 4 5 6
<b>Special Notes</b> (yeasts, parasites, other)			
<b>Update recommendations &amp; supplements</b>			

<b>Treatment 3</b>		<b>Date:</b>	
<b>Description of matter:</b>	Amount	Bloating	Gas
	x xx xxx	x xx xxx	x xx xxx
	Undigested Food	Bowel Tone	On Bristol Stool Scale:
	x xx xxx	x xx xxx	1 2 3 4 5 6
<b>Special Notes</b> (yeasts, parasites, other)			
<b>Update recommendations &amp; supplements</b>			

<b>Treatment 4</b>		<b>Date:</b>	
<b>Description of matter:</b>	Amount	Bloating	Gas
	x xx xxx	x xx xxx	x xx xxx
	Undigested Food	Bowel Tone	On Bristol Stool Scale:
	x xx xxx	x xx xxx	1 2 3 4 5 6
<b>Special Notes</b> (yeasts, parasites, other)			
<b>Update recommendations &amp; supplements</b>			