bodicare
complete health and well being

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COLONIC HYDROTHERAPY

Please complete this questionnaire and bring it to your treatment or e mail back of you prefer.

Name:	Email:	
Address:	DOB:	Have you had colonics before? Y N
	Age:	What therapies do you use regularly?
	Weight:	
Mob/Tel:		

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

Kick-start / maintain health	Irregular bowel movements	Lack of energy	Skin problems
Detox	Constipation	Food cravings	Allergies
Help with weight loss	IBS/Bloatedness	Mood swings	Parasites
Increase energy	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 ☐	I don't take milk ☐	I smoke & drink	I snack on sweets/chocolate ☐
I drink 8 glasses of water/day ☐	I don't eat wheat ☐	I chew thoroughly	I often overeat
I exercise enough ☐	I eat salads/vegetables ☐	I eat quickly	I have big meals after 8 pm ☐
I do not exercise enough ☐	I eat rice, barley etc ☐	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:

☐ Cancer of Colon or Rectum ☐ Gastric Intestinal perforation ☐ Active fissures/fistulae ☐ Recent colon/rectal surgery ☐ Cirrhosis or abdominal hernia

☐ Unmonitored High BP ☐ Severe Anaemia ☐ Pregnancy-1st 3 months ☐ Kidney problems ☐ Severe Heart Disease

Please tick if you have had any of the following:

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Hepatitis
☐ Rheumatic Fever ☐ Thyroid Disease ☐ Seizures ☐ Prolapse(s) ☐ Other

Please add any information on operations/surgeries in the last 5 years.

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

Please sign this questionnaire to confirm that you have not omitted any information relevant to this treatment.

Signature: Date: