Ashtead Healthy Living
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Jane Ranger
Colon Hydrotherapist

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	I don't take dairy	I smoke & drink	I snack on sweets/chocolate
I drink 8 glasses of water/day	I don't eat wheat/gluten	I chew thoroughly	I often overeat
I exercise enough	I eat salads/vegetables/raw foods	I eat quickly	I have big meals after 8 pm
I do not exercise enough	I take laxatives	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:

☐ Severe Cardiac Disease ☐ Severe Anaemia ☐ Active fissures/fistulae ☐ Recent colorectal surgery ☐ Cirrhosis or abd. hernia
☐ Unmonitored High BP ☐ GI haemmorage/perf ☐ Pregnancy ☐ Renal insufficiency
☐ Crohns ☐ Diverticulitis ☐ Ulcerative Colitis ☐ Colorectal carcinoma

Please check if you have had any of the following:

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Hepatitis
☐ Rheumatic Fever ☐ Thyroid Disease ☐ Seizures ☐ Thrush ☐ Bloating
☐ Headaches ☐ Haemorroids

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: