The Footparlour,
448, Burnage Lane, Manchester. M19 1LH
0161 432 3787

**Colonic Irrigation Questionnaire. Please answer honestly.**

| Name: | Email: | |
|---|---|---|
| Address: | Sex: M / F | Have you had colonics before? Y/ N |
| | DoB: | |
| | Weight: | |
| Mob/Tel: | | |

**Reasons/Motivation 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/migraine s |

**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 salad/veg sssssalad/vegsalad salads/vegetables ↑ | I eat quickly | I have big meals after 8pm ↑ |
| 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.***

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**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:**

| | | | | |
|---|---|---|---|---|
| o Severe Cardiac Disease | o Severe Anaemia | o Active fissures/fistulae | o Recent colorectal surgery | o Cirrhosis or abdominal hernia |
| o Unmonitored High BP | o GI perf or haemorrhage | o Pregnancy 1st trimester | o Renal insufficiency | o Colorectal carcinoma |

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

| | | | | |
|---|---|---|---|---|
| o Cancer | o Diabetes | o High Blood Pressure | o Heart Disease | o Hepatitis |
| o Rheumatic Fever | o Thyroid Disease | o Seizures | o Prolapse(s) | o 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.

**Please sign and date this questionnaire.**
**By signing this form I accept the 'Terms and Conditions of Booking' printed on the advice & reference page:**

Signature: Date: