CONFIDENTIAL HEALTH QUESTIONNAIRE

Date:

Surname:……....
Forename:……..
Address:……..
……..
……..Tel:……
mob:……...email:…….

Age……DOB…….
Sex:……...
Height:……Weight:……
Marital status……Children:…….....

Interests:……....……Occupation:…….

Main reason for coming:

Your own brief description of disorders / troubles in a general order of priority:

1.
2.
3.
4.

How often are your bowel movements generally?

Amount Daily weekly

Genito – Urinary

Kidney Infections or stones
Painful urination
Prostrate trouble
Kidney Failure
Frequent urination

Women's problems

Painful menstruation
Absent periods
Vaginal discharges
Breast pain
Last menstrual period
Are you Pregnant
Any abortions

Do you have	HEAVY	MODERATE	LIGHT	NONE
ALCOHOL				
COFFEE				
TEA				
TOBACCO				
DRUGS				
EXERCISE				
SLEEP				
APPETITE				

Please list any of the following medication you have taken in the last 4 years

ANACIDS	HEART Medication	LAXATIVES
ANTIBIOTICS	HIGH BLOOD PRESSURE	STERIODS
ASPIRIN / Paracetamol	DIURETICS	TRANQUILIZ
INSULIN	ORAL CONTRACEPTION	ULCER Md

Please list what your medication/s are for

Have you had any operations or Hospitalisations?

Do you suffer colds or Flu Regularly?

Family & Predisposing History

Please tick if you suffer from any below. Or * for family

General
Headaches
Insomnia (loss of sleep)
Dizziness
Fainting Spells
History of seizures
Fatigue
Depression
Enlarged Thyroid
Double blurred vision
Allergies
Hay Fever
Bad breathe
Cancers

Gastro Intestinal
Colitis
Constipation
Crohn's disease
Diverticulitis
Diverticulosis
Gall bladder disease
Haemorrhoids
Fissure/ Fistulas
Liver trouble
Cirrhosis
Rectal bleeding
Vomiting of blood
Colon

Respiratory
Shortness of Breath
Chronic cough
Vomit blood
Emphysema
Bronchitis
Asthma

Skin
Bruise easily
Dryness
Itching
Psoriasis
Eczema

Cardiovascular
High blood pressure
Hardening of the arteries
Angina
Poor circulation
Irregular Heart beat
Congestive heart failure
Swelling of ankles
Diabetes

Muscle & Joints
Arthritis
Bursitis
Lower back pain
Stiffness/ Back pain
Other specific pains:
Fibromyalgia
M.S
C.F.S or M.E

Have you had a colonic before?

Where did you hear of the clinic?

Have you undergone a cleansing programme before?

Please list any SUPPLEMENTS (Vitamins & Minerals inc drinks)

Are you vegetarian or vegan?

Do you diet for weight reasons?
Do you have a limited / specialised diet?

Do you have any particular foods you really cannot stand?

Do you crave foods?

Which are your favourite type foods / texture/ tastes?

……..

Signed declaration certifying that all relevant information has been provided and discussed, is true and that client gives consent to treatment and digital rectal examination or any subsequent treatment if and when required.

Client signature……..

Date ……