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/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 drink fizzy drinks ↑	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↑	I eat quickly	I have big meals after 8pm ↑
I chew gum	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.*

Occupation	**Volume of (pintd/glasses/litres)**
	Water
B/Fast	**Tea**
	Coffee
Lunch	**Herbal Tea**
	Alcohol
E.Meal	**Cordial**
Snacks	**Stress Levels 1 - 5**
	LO High

Describe your typical bowel movements: frequency, amounts and appearance

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

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: