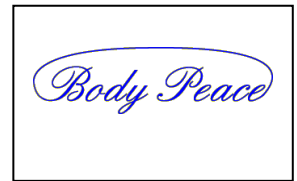




BODY PEACE COMPLEMENTARY MEDICINE CENTRE
 122 Nursery Road, Taplow, Berkshire, SL6 0JU
 Tel: 01628 66 22 55
 E-mail: info@bodypeace.co.uk
 Website: www.bodypeace.co.uk



Colonic Irrigation Questionnaire - Please fill this questionnaire and bring it with you to your treatment.

Surname:	Have you had colonics before: Y N		
Name:	Sex:	What therapies do you use regularly?	
Telephone No:	Age:		
Mobile:	E-Mail:		

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

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Severe Cardiac Disease | <input type="checkbox"/> Severe Anaemia | <input type="checkbox"/> Active fissures/fistulae | <input type="checkbox"/> Recent colorectal surgery | <input type="checkbox"/> Cirrhosis or abd. hernia |
| <input type="checkbox"/> Unmonitored High BP | <input type="checkbox"/> GI haemorrhage/perf | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Renal insufficiency | <input type="checkbox"/> Colorectal carcinoma |
| <input type="checkbox"/> Crohns | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Ulcerative Colitis | | |

Please check if you have had any of the following:

- | | | | | |
|--|--|--|--|------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Thrush | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> 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 (continue on the reverse if needed):

Signature:

Date:



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Colonic Irrigation Treatment Consent Form

I confirm that I have provided, to the best of my knowledge & ability, the relevant information about my health & lifestyle.

I agree to receive colon hydrotherapy from _____ and to inform my therapist of any relevant changes in my health and lifestyle. I have understood the treatment that I am consenting to and confirm that I have no reason to consult with my GP before undergoing the treatment.

Signature: _____

Date: _____

Health Questionnaire Update.

For each subsequent treatment briefly describe changes or write "None", as appropriate.

Signature:

Date:

Health Questionnaire Update.

For each subsequent treatment briefly describe changes or write "None", as appropriate.

Signature:

Date:

Health Questionnaire Update.

For each subsequent treatment briefly describe changes or write "None", as appropriate.

Signature:

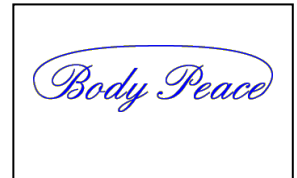
Date:

Health Questionnaire Continuation Section (if required):

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COLONIC THERAPY – OBSERVATION FORM

Name			
Main concerns			
Treatment 1		Date:	
Description of matter:	Amount	Bloating	Gas
	x xx xxx	x xx xxx	x xx xxx
Undigested Food	Bowel Tone	On Bristol Stool Scale:	
	x xx xxx	x xx xxx	1 2 3 4 5 6
Special Notes (yeasts, parasites, other)			
Update recommendations & supplements			

Treatment 2		Date:	
Description of matter:	Amount	Bloating	Gas
	x xx xxx	x xx xxx	x xx xxx
Undigested Food	Bowel Tone	On Bristol Stool Scale:	
	x xx xxx	x xx xxx	1 2 3 4 5 6
Special Notes (yeasts, parasites, other)			
Update recommendations & supplements			

Treatment 3		Date:	
Description of matter:	Amount	Bloating	Gas
	x xx xxx	x xx xxx	x xx xxx
Undigested Food	Bowel Tone	On Bristol Stool Scale:	
	x xx xxx	x xx xxx	1 2 3 4 5 6
Special Notes (yeasts, parasites, other)			
Update recommendations & supplements			

Treatment 4		Date:	
Description of matter:	Amount	Bloating	Gas
	x xx xxx	x xx xxx	x xx xxx
Undigested Food	Bowel Tone	On Bristol Stool Scale:	
	x xx xxx	x xx xxx	1 2 3 4 5 6
Special Notes (yeasts, parasites, other)			
Update recommendations & supplements			

Treatment 5		Date:	
Description of matter:	Amount	Bloating	Gas
	x xx xxx	x xx xxx	x xx xxx
Undigested Food	Bowel Tone	On Bristol Stool Scale:	
	x xx xxx	x xx xxx	1 2 3 4 5 6
Special Notes (yeasts, parasites, other)			
Update recommendations & supplements			

Treatment 6		Date:	
Description of matter:	Amount	Bloating	Gas
	x xx xxx	x xx xxx	x xx xxx
Undigested Food	Bowel Tone	On Bristol Stool Scale:	
	x xx xxx	x xx xxx	1 2 3 4 5 6
Special Notes (yeasts, parasites, other)			
Update recommendations & supplements			