Inner Health Clinic
Ruth Tansey
Saks Hair & Beauty
Cheadle Royal, Cheadle Crescent , Stockport
SK8 3FL

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

Surname:	Have you had colonics before: Yes No	
Name:	Sex:	What therapies do you use regularly?
Telephone No:	Age:	
Mobile:	E-Mail:	
Would you like to be notified about offers for colonic hydrotherapy? Yes No		

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/Bloating	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 abdominal hernia
☐ Unmonitored High BP	☐ GI haemorrhage/perf	☐ Pregnancy	☐ Renal insufficiency	☐ Colorectal carcinoma
☐ Crohns	☐ Diverticulitis	☐ Ulcerative Colitis		

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	☐ 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: