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Bexley Wellness
Combining the benefits of colonic hydrotherapy, detox and nutrition

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

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

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 ☐	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 abd. hernia
☐ Unmonitored High BP ☐ GI haemmorage/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:

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Colonic Irrigation Treatment Consent Form

Name_____ **Surname**_____

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

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

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

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