Therapy Corner Colonics
89a Moulsham Street, Chelmsford, Essex, CM6 1RF
Tel: 07977225857 or 01279877745
lindsey@therapycorner.co.uk or visit
www.therapycorner.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 ☐	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):

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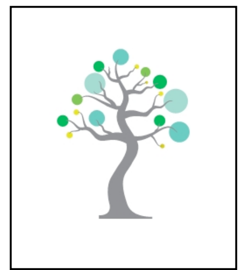

Colonic Irrigation Treatment Consent Form

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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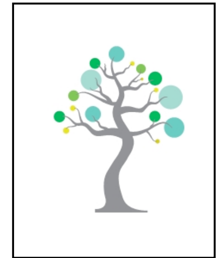

COLONIC THERAPY – OBSERVATION FORM

Name	
Main concerns	

Treatment 1	***Date:***		
Description of matter:	*Amount* *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			

Treatment 5	***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 6	***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			