

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 have a balanced diet ↑	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 sssss salad/vegsalad salads/vegetables ↑	I eat quickly	I have big meals after 8pm ↑
I do not exercise enough ↑	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.**

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**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 abdominal hernia |
| <input type="checkbox"/> Unmonitored High BP    | <input type="checkbox"/> GI perforation or haemorrhage | <input type="checkbox"/> Pregnancy 1st trimester  | <input type="checkbox"/> Renal insufficiency       | <input type="checkbox"/> Colorectal carcinoma          |

**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"/> Prolapse(s)   | <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.

**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: