Colonics Wirral.uk

www.colonicswirral.uk

# CLIENT CONSENT AND MEDICAL HISTORY FORM

**Please complete the following in BLOCK CAPITALS**

**All information is kept strictly confidential.**

| | |
|---|---|
| **Full Name:** | |
| **Address:** | |
| **Postcode:** | **Contact Number:** |
| **Email address:** | |
| **Occupation:** | |
| **GP Name:** | **GP Contact Number:** |
| **Address of GP:**<br>**Postcode:** | |

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## Your Medical History

| CONDITION | ADDITIONAL DETAILS<br>PLEASE STATE IF THERE IS A FAMILY HISTORY |
|---|---|
| Heart problems e.g. Angina, heart attack, high blood pressure? **YES/NO** | Any Details: |
| Lung problems e.g. Asthma/other breathing difficulties? **YES/NO** | Any Details: |
| Diabetes? **YES/NO** | Any Details: |
| Epilepsy? **YES/NO** | Any Details: |
| Liver problems e.g. Jaundice, Hepatitis, Cirrhosis? **YES/NO** | Any Details: |
| Abdominal hernia? **YES/NO** | Any Details: |
| Haemorrhoids? **YES/NO** | Any Details: |
| Are you presently under medical supervision or taking medications (current and most recent)? **YES/NO** | Any Details: |
| State all past surgical procedures and approximate dates. | Any Details: |
| Are you pregnant? **YES/NO** | Any Details: |
| Do you drink alcohol? **YES/NO** | How many units per week? |
| Antibiotics taken the past to be: (Please Circle) | Average – higher than average – lower than average |
| Do you smoke? **YES/NO** | How many per day? |

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| Do you take mineral/vitamin supplements? **YES/NO** | Please list: |
| Do you use herbal or homeopathic remedies? **YES/NO** | Please list: |
| Do you drink tea or coffee? **YES/NO** | How many cups per day? |
| Do you consume foods containing sugar – i.e. chocolate? **YES/NO** | How often? |
| Do you exercise? **YES/NO** | How often? |
| How often do you have a bowel movement? | Give Details: |
| Describe usual colour and consistency | Give Details: |
| Any family history of Crohn's Disease; Ulcerative Colitis or cancer/related conditions? **YES/NO** | Give Details: |
| **FEMALE:** Have you suffered any of the conditions shown opposite (Please circle): | Premenstrual depression/tension<br>Extremely heavy menstrual flow<br>Menstrual pain<br>Endometriosis<br>Failure/little menstrual flow<br>Vaginal discharge |
| **MALE:** Have you ever suffered from an enlarged prostrate? **YES/NO** | Any Details: |
| **MALE/FEMALE:** Are you suffering or have you suffered from any of the following symptoms?<br><br>Abdominal pains? **YES/NO**<br><br>Distension or bloating of the lower abdomen? **YES/NO** | Any Details: |

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| Chronic indigestion/heartburn? **YES/NO**<br><br>Diarrhoea? **YES/NO**<br><br>Gastritis? **YES/NO**<br><br>Rectal itching? **YES/NO**<br><br>Mucus in stools? **YES/NO** | |
| Do sugar rich foods have an aggravated affect on your system? **YES/NO** | Give Details: |
| Do you suffer from any Allergies? **YES/NO** | Give Details: |
| I (Your Name)……<br>Give my permission to proceed with treatment which includes a digital examination as explained by my colonic practitioner. I understand that after care advice will also be provided. | **Signed:**_____<br><br>**Print name:**_____<br><br>**Date completed:**_____ |
| Practitioners Name (Please print):<br><br>Practitioners' Signature:<br><br>Date:: | |