

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:	
Postcode:	



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Your Medical History

CONDITION	ADDITIONAL DETAILS 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? <p style="text-align: center;">YES/NO</p>	Please list:
Do you use herbal or homeopathic remedies? <p style="text-align: center;">YES/NO</p>	Please list:
Do you drink tea or coffee? YES/NO	How many cups per day?
Do you consume foods containing sugar – i.e. chocolate? <p style="text-align: center;">YES/NO</p>	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 Extremely heavy menstrual flow Menstrual pain Endometriosis Failure/little menstrual flow Vaginal discharge
MALE: Have you ever suffered from an enlarged prostate? YES/NO	Any Details:
MALE/FEMALE: Are you suffering or have you suffered from any of the following symptoms? Abdominal pains? YES/NO Distension or bloating of the lower abdomen? YES/NO	Any Details:



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Chronic indigestion/heartburn? YES/NO Diarrhoea? YES/NO Gastritis? YES/NO Rectal itching? YES/NO 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)..... 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: _____ Print name: _____ Date completed: _____
Practitioners Name (Please print): Practitioners' Signature: Date::	

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