Colchester clinic ltd

consultation form

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Name: _____ Age_____ DOB _____

Address_____

_____

Email:_____ Tel Mobile:_____

Occupation:_____ Weight:_____ Height:_____ Marital Status:_____

BP:_____

DoctorsName/Add:_____

_____

_____Referred by: _____Doc Tel_____

Tel Home:_____ Children:_____

Please state the reason for treatment:_____

_____

_____

_____

Please state any history of disease_____

_____

_____

What is a typical days diet for you?

_____

_____

_____

_____

_____

Are you currently taking any medication? If so please state what you are taking?:

_____

Are you currently taking any supplements? If so please state what you are taking_____

_____

Do you suffer any allergies?:

_____

Do you suffer any urinary tract problems?:

_____

Do you smoke? If so how many a day?:

_____

Do you have any skin complaints?:

_____

SEVERE HYPERTENSION
RECENT COLON RECTAL SURGERY
FISSURES OR FISTULAS
ANEURYSM
KIDNEY FAILURE
PREGNANCY

CARCINOMA OF THE COLON
HEART FAILURE
SEVERE ANAEMIA
THROMBOSED HAEMORRHOIDS
GASTROINTESTINAL

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How much water do you drink in a day?:_____

How would you rate your concentration out of 10?:_____

Do you suffer with anxiety or depression?

_____

Do you suffer headaches and if so what triggers them and where is the pain in your head?: _____

_____

_____

How often do you have bowel movements?:_____

Are they comfortable?:_____

Do they feel complete?:_____

Do you experience Burping, refluxing or acidity?:_____

Do you suffer with bad breath?:_____

Do you suffer with haemorrhoids?: _____

Have you ever taken antibiotics on a regular basis?: _____

_____

Do you ever suffer from anal itching?: _____

WOMEN ONLY: Is there any possibility you could be pregnant?:_____

Do you have regular or irregular periods?:

_____

Do you suffer with vaginal thrush frequently?:_____

NOTES:_____

_____

_____

_____

_____

_____

_____

_____

_____

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Name: _____

Treatments:

Colchester Clinic ltd

Consultation form

TREATMENT CONSENT FORM

Please read through this form, you will be asked to sign it upon arrival at Colchester Clinic ltd

If any of the below apply to you then please inform the clinic before your appointment. You may still be able to have the treatment but the therapist will need to discuss with you beforehand.

I freely give my consent to receive a colon hydrotherapy treatment and accept full responsibility for that decision. I have informed (Colchester Clinic Ltd) of any medical conditions which I believe could affect my treatment. I understand that colon hydrotherapy is part of an overall approach to diet and lifestyle, and that it is not a medical treatment. I have been made aware of the medical conditions which are contraindicated with colon hydrotherapy and these are as follows:

- Recent surgery to colon, rectum, or abdomen (less than 12 weeks). Recent laparoscopy (less than 3 weeks)
- Carcinoma of the colon or rectum. Recent bowel biopsy (3 weeks partial; 6 weeks full thickness)
- Bowel perforation. Long-term oral, or rectal, steroid use (weakens bowel wall)
- Severe Haemorrhoids (or badly inflamed). Severe haemorrhaging
- Autonomic dysreflexia (impaired, or difficult reflex response, occurring in spinal injuries at or above T6)
- Hirschsprung's disease (megacolon)
- Paralytic ileus (obstruction of the small intestine)
- Severe hypertension (uncontrolled). Blood pressure above 160/100. Severe Anaemia
- Any active inflammatory bowel condition, for example: diverticulitis, colitis, Crohn's disease.
- Severe abdominal, or inguinal (groin), hernia which cannot be reduced
- (First 20 weeks). Complicated pregnancy, or history of unstable pregnancy
- Severe heart disease (uncontrolled). Congestive heart disease.
- Carcinoma of the kidney. Kidney disease. Renal insufficiency (using dialysis)
- Use of diuretics (water used during treatment could raise blood pressure)
- Carcinoma of the liver. Severe liver disease (cirrhosis). Gall bladder disease
- Fissures (an anal fissure is a break in the lining of the bowel; usually occur as a consequence of constipation)
- Fistulas (abnormal connection of tissue; anal fistula may develop after an abscess in the rectum has burst)
- Hip joint or knee joint surgery (within 6 months)
- Hysterectomy (less than 12 weeks)
- (Children under 16 years of age without GP's, or medical specialist written referral)
- I give consent to the therapist giving a digital rectal exam (DRE) on the first consultation if they deem it necessary.

I acknowledge that any notification of appointment cancellation or change of appointment must be undertaken within 24 hours of said appointment. Cancellations later than 24 hours will require payment of the full fee. Any fee increases will commence in the January of the given year. I also acknowledge that my commitment to the content of this consent form is in part a commitment to my own treatment, and a personal ownership of that.

In line with the General Data Protection Regulation (GDPR) your data and personal information will never be shared with third parties and all consultation forms and notes containing your personal information are stored in locked filing cabinets and a pin secured mobile telephone. By signing this form you acknowledge and understand our commitment to GDPR and give consent for us to hold your private information as stated above.

Signature:…… Date:……