Client Consultation Form

Please complete this Consultation Form and bring it with you to your appointment.

Section A (Applicable to all treatments)

Name:	Male	☐	Female	☐	DoB:				
Address:									
Preferred Contact No:	Single	☐	Married	☐	Children	☐			
E-mail address:	Hours worked per week:								
How did you hear about Complete Health Clinic?	Google ☐	Existing Client ☐	Referral ☐	Lowry Spa ☐					
Other (please specify)									
GP's Name and Address:									
Occupation:									
Are you being treated for any medical condition – please give details:									
Please list any medication you are currently taking:									
Please list any surgical procedures you have had with dates performed:									
Do you regularly take antibiotics – please give details									
Male: Do you have any prostate problems?	Yes ☐	No ☐							
Female: Is there any possibility you may be pregnant?	Yes ☐	No ☐							
Do you have any children? Yes ☐ No ☐	Age(s):	Birth: Natural/Caesarean							
Do you have a contraceptive pill / implant etc?	Yes ☐	No ☐							
Do you have a regular menstrual cycle? Yes ☐	No ☐	Date of last period:							
Painful? Yes ☐	No ☐								
Have you suffered any miscarriage in the last 2 years?	Yes ☐	No ☐							
Have you had a hysterectomy?	Yes ☐	No ☐							

Section A (Applicable to all treatments - Continued)

Do you have Botox?	Yes		No		If so, when was the last time?	
Do you have any food allergies or intolerances? If so, please give details						
Do you drink water daily?				How many glasses a day?		
Do you smoke?				How much daily?		
Do you drink alcohol? If so, how many units a week? (2 units is a pint normal strength lager or 3 units is a strong lager, 1 units single spirits 25ml, 7-9 units 75cl bottle of wine)						
Do you drink tea or coffee?				How many cups a day?		
Do you crave sweet things?				If so, how?		
Do you consume other types of drinks eg fizzy drinks, juice, cordial? If so, how many glasses a day?						
Do you exercise?				If so how often?		

Section B (please complete this section if you are having a colonic hydrotherapy treatment)

Have you had a colonic before?	Yes		No		
Are you seeing any other practitioners at present? Please detail					
Do you take any vitamin / mineral supplements?					
Do you take any herbs or homeopathic remedies?					
Are you Vegetarian?					

Bowel Habits

How often do you open your bowels in a week?									
Do you suffer bloating?	Yes		No		Do you suffer constipation?	Yes		No	
Do you suffer diarrhoea?	Yes		No		Do you take any laxatives?	Yes		No	
What laxatives do you take and how often do you take them?									
Have you been diagnosed with Irritable Bowel Syndrome?			Yes		No				
Diagnosed?	Yes		No		Active at present?	Yes		No	Constipation/Diarrhoea/both
Have you been diagnosed with Diverticulitis?	Yes		No						
Have you been diagnosed with Chron's Disease	Yes		No						
Have you been diagnosed with Colitis / Ulcerative Colitis?			Yes		No				

Please tick which type of bowel movements you have			
Separate hard lumps, like nuts (hard to pass)		Sausage shaped but lumpy	
Like a sausage but with cracks on the surface		Like a sausage or snake, smooth and soft	
Soft blobs with clear-cut edges		Fluffy pieces with ragged edges, a mushy stool	
Watery, no solid pieces, entirely liquid		Other	
Do you use anything to create a bowel movement?			
If so, what and how regularly?			

Reasons for the treatment (tick the ones that apply to you)					
Kick-start healthy living		Irregular bowel movements		Increase energy	
Skin problems		Detox		Health maintenance	
Constipation		Parasites		Food cravings	
Allergies		IBS / Bloated		Help with weight loss	
Headaches / Migraines		Yeasts / Candida		Diarrhoea	
Mood Swings		Other			

Section B (Continued)

Contraindications: do you suffer from any of the following?

	YES		NO	
Severe Anaemia – Risk of fainting				
Severe haemorrhoids				
Colon, rectal, bowel cancer				
Abdominal hernia				
Aneurism				
Perforation of digestive tract / gut				
Autonomic dysreflexia (occurs in spinal injuries at or above T6)				
Congestive heart disease				
Fistula				
Hirschsprung's disease				
Hypertension (High Blood Pressure) – Sever or uncontrolled				
Ileus (paralytic)				
Inflamed haemorrhoids				
Pregnancy				
Rectal bleeding				
Radiotherapy of abdominal area not discharged from medical care				
Renal insufficiency (kidney function less than 50%)				
Severe persistent diarrhoea				

Please tick anything that you may suffer from
Gastrointestinal System & Urinary System

Chronic Heartburn		Vomiting of blood		Rectal itching	
Constipation		Cancer Diverticulosis		Cancer	
Abdominal bloating		Haemorrhoids		Diverticulitis	
Diarrhoea		Colitis		Gall Bladder Disease	
Mucous in stools		Excessive gas		Liver trouble	
Indigestion		Fissures		Family Colon Cancer	
Ulcerative Colitis		Rectal bleeding		Abdominal pain	
Cirrhosis		Fistulas		Prostate problems	
Cystitis		Kidney infection		Kidney Stones	
Vaginal discharge		Breast pain			

General Health
Do you have any problems with the following?

Weight		Heart		Headaches	
Lungs					

Any other health problems?

As far as you are aware, are you allergic to : Liquorice, Fennel, Artichoke, Senna, Chamomile, Raspberry Leaf, Dandelion, Coffee and Probiotics?

Yes / No Please detail

Other Allergies:

Declaration

Declaration: I declare that the information I have given is correct and complete.

I agree to undergo a digital rectal examination and subsequent colonic hydrotherapy treatment and receive enema herbs as part of my treatment if recommended.

If suffering from diabetes, angina, heart disease or epilepsy, in the event of an attack, I agree to the following action being taken: (please indicate your choice)

- Administer my medication
- Call ambulance
- Call relative
- Position comfortably

By signing this form, I confirm and agree that any treatments are at my own risk, other than in relation to any physical or mental harm I suffer due to negligence and without limiting or affecting any statutory rights I may have.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Data Protection

I consent to my data being used for the purposes of documentation and communication in regard to the treatment I am undertaking:	YES	NO

I consent to my data being used for the purpose of marketing contact by:

E-mail	Yes		No		**Telephone**	Yes		No		**Message**	Yes		No		

I understand any data and documentation will be stored securely. It will only be sued for the specific information concerning my treatment and stored for no longer than necessary.

It will not be passed to any third party without my consent.

I understand you may hold my data on electronic devices with password protection and paper, which will be stored securely.

Client Signature:

Date: