Look after yourself...there is only one you

COMPLETE HEALTH CLINIC

CONSULTATION FORM

Please complete this consultation form and bring it with you to your appointment.

Section A (applicable to all treatments)

Name: _____ Sex: M ☐ F ☐ DOB: _____

Address: _____

_____ Family: Married ☐ Single ☐ Children ☐

Preferred Contact No: _____

Email Address: _____

Occupation: _____ Hours worked per week: _____

Where did you hear about Complete Health Clinic?: Google ☐ Place of Treatment ☐ Referral ☐ Previous Client ☐

Other (please specify): _____

GP'S Name & Address: _____

_____

Are you currently being treated for any medical condition – give details: _____

_____

Please list medication you are currently taking: _____

_____

Please list any surgery procedures you have had with dates performed: _____

_____

Do you regularly take antibiotics? _____

_____

Are you pregnant? Y ☐ N ☐ If so how many weeks? _____

Do you have botox? Y ☐ N ☐ 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 unit single spirits 25ml, 7-9 units 75cl bottle of wine)

Do you drink tea and or coffee? _____ How many cups per day? _____

Do you crave sweet things? _____ If so, how often? _____

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? _____

Please tick anything that you may suffer from:

GENERAL

Persistent Headaches ☐ History of seizure ☐ Insomnia ☐ Loss of weight ☐ Dizziness ☐ Mood swings ☐
Double/Blurred vision ☐ Enlarged Thyroid ☐ Fatigue ☐ Fainting spells ☐ Depression ☐ Irritability ☐

RESPIRATORY

Shortness of breath ☐ Chronic cough ☐ Emphysema ☐ Bronchitis ☐ Asthma ☐ Hayfever ☐ Sinus problems ☐

MUSCLES AND JOINTS

Arthritis ☐ Bursitis ☐ Lower back pain ☐ Neck pain ☐ Other pain ☐ Swollen joints ☐

CARDIOVASCULAR

High blood pressure ☐ Hardening of arteries ☐ Angina (chest pains) ☐ Varicose veins ☐
Poor circulation ☐ Rapid/Irregular heartbeat ☐ Swelling of ankles ☐

SKIN

Bruise easily ☐ Dryness ☐ Itching ☐ Rash ☐ Acne ☐ Eczema ☐ Psoriasis ☐

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

Have you had a colonic before? Y ☐ N ☐

How often do you open your bowels? _____

Are you seeing any other practitioners at present? _____

Do you take any vitamin/mineral supplements? _____

Do you take and herbs or homeopathic remedies? _____

Are you Vegetarian? _____

Please tick which type of bowel movements you have:

Separate hard lumps, like nuts (hard to pass) ☐
Like a sausage but with cracks on the surface ☐
Soft blobs with clear-cut edges ☐
Watery, no solid pieces, entirely liquid ☐
Sausage shaped but lumpy ☐
Like a sausage or snake, smooth and soft ☐
Fluffy pieces with ragged edges, a mushy stool ☐

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 ☐

Please tick anything that you may suffer from:

GASTROINTESTINAL SYSTEM

Chronic Heartburn ☐ Vomiting of blood ☐ Crohn's disease ☐ Rectal itching ☐ Constipation ☐ Cancer ☐
Cancer Diverticulosis ☐ 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 ☐

URINARY

Cystitis ☐ Kidney infection ☐ Kidney stones ☐ Vaginal discharge ☐ Breast pain ☐ Date of last period _____

Please check whether you have any of the following conditions for which this treatment is contraindicated:

Severe Cardiac disease ☐ Active fissures/fistulas ☐ Cirrhosis or adb. hernia ☐ Severe Anaemia ☐ Pregnancy ☐
Unmonitored high BP ☐ GI heaemorrhage's/perf ☐ Recent colorectal surgery ☐ Colorectal Carcinoma ☐

Section C (applicable to all treatments)

OTHER RELEVANT INFORMATION

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. If taking part in a colonic hydrotherapy treatment I also give consent for the Therapist to perform a digital rectal examination prior to treatment.

(Personal data provided will be stored in a secure environment, in compliance with the Data Protection Act 1998)

Clients Signature _____ Date _____

Therapist Signature _____ Date _____

HELEN O'BRIEN
COLONIC & HOLISTIC THERAPIST
0161 2074034 079000 82080
helen@completehealthclinic.co.uk
completehealthclinic.co.uk
SEPTEMBER BARN, BROWN EDGE FARM, NEWCASTLE ROAD, BRERETON, CW11 1SB