

H.Y.H.U.a ci bh7]b]W
Capel Grange, Bedford Road, Holwell
Hitchin, Hertfordshire SG5 3RT

Telephone Number: 01462 712500
www.taymount.com

Health Questionnaire

In strictest confidence

Full Name _____

Address _____

Telephone number _____ (best to reach you on)

Email address _____

Date of Birth _____ Age _____ Height _____ Weight _____

Occupation _____

Have you received any antibiotic treatment in the past six months? Yes No

Marital Status Single Married Divorced Separated Widowed

Do you have any children? Yes No If yes, how old? _____

Current health complaints _____

Please list any medications you are taking _____

List all surgical procedures in the last two years _____

Are you taking any vitamin/mineral supplements? Yes No

If yes, are these prescribed self-prescribed ?

If yes, please list _____

How long have you been taking them? _____

Are you currently consulting any other practitioners? If so please give details of the treatment you are receiving

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Any family health conditions _____

How often do you urinate? 3-4 times a day Less More

Any back pain? Yes No How often? _____

How regular are your bowel movements? _____

Is there ever any mucous in your stools? Yes No _____

Does stress affect your bowel movements? Yes No _____

Do you crave any particular type of food? Yes No Please list _____

Do you smoke Yes No How many a day? _____

Do you drink alcohol Yes No How much a week? _____

Do you drink coffee Yes No How many cups per day? _____

Do you Add Milk Yes No Do you add sugar Yes No

Do you drink tea Yes No How many cups per day? _____

Do you Add Milk Yes No Do you add sugar Yes No

Do you drink soft drinks (cola etc) Yes No How many glasses per day? _____

Do you drink water Yes No How many glasses per day? _____

Do you exercise Yes No How often? _____

How many hours sleep do you need/get _____

Do you have a good appetite Yes No

Do you suffer from any allergies/food sensitivities Yes No

If yes please list _____

Do you frequently travel abroad Yes No

Are you under a lot of stress Yes No

Daily diet - please give an indication of a typical daily diet

Breakfast _____

Mid Morning _____

Lunch _____

Mid afternoon _____

Dinner _____

Have you ever suffered from Anorexia or Bulimia Yes No

Do you ever overeat? Yes No

Are you vegetarian or vegan? vegetarian vegan neither

Do you feel that certain foods upset you _____

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Additional information

Please give any other information you think relevant _____

List your main reasons for wanting colon hydrotherapy or wanting to do a detox _____

How did you hear about Homefield Grange Retreat _____

The information provided above is, to the best of my knowledge, true and accurate.

Signature _____

Date _____

I appreciate that colonic hydrotherapists do not give medical diagnosis or medical treatment. I agree to having a rectal examination if during discussion with my therapist it is deemed necessary.

Signature _____

Date _____

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Please tick if you suffer, or have suffered, from any of the following conditions:

General

- Alcoholism
- Amalgam Fillings - How many
- Anaemia
- Cancer (of any type)
- Chronic Fatigue Syndrome
- Diabetes
- Dizziness
- Double/Blurred Vision
- Drug Addiction
- Fainting Spells
- Ear Infections
- Epilepsy
- Headaches/Migraines
- Hepatitis
- HIV/Aids
- Hypoglycaemia
- M.E.
- Loss of Weight
- Over Active Thyroid gland
- Under Active Thyroid Gland
- Other

Cardiovascular

- Angina (Chest Pains)
- Hardening of the Arteries
- Low blood pressure
- Rapid/Irregular heart beat
- Swelling of the ankles
- Other

Emotional/Nervous System

- Anxiety
- Depression
- Fatigue
- Insomnia
- Irritability
- Lack of concentration
- Lethargy
- Mood Swings
- Over Reacting
- Panic Attacks
- Poor Memory

Respiratory

- Asthma
- Bronchitis
- Emphysema
- Hay Fever
- Sinus Problems

Genito-Urinary

- Bladder Infections
- Kidney Infections/Stone
- Other

Gastro-Intestinal

- Abdominal pain
- Bad Breath
- Colitis
- Constipation
- Craving
- Diarrhoea
- Distension & Bloating of Abdomen
- Diverticulitis /Diverticulosis
- Heartburn
- Indigestion
- Irritable Bowel Syndrome
- Liver Trouble
- Rectal Bleeding
- Rectal Itching
- Ulcerative Colitis
- Other

Muscle and Joint

- Arthritis
- Low Back Pain
- Joint Pain/Stiffness
- Muscle Sclerosis
- Muscle Weakness
- Other

Skin

- Acne
- Bruise Easily
- Dermatitis
- Eczema
- Fungal Infections
- Psoriasis

Women

- Amenorrhoea (Absence of Periods)
- Dysmenorrhoea (Painful Periods)
- Endometriosis
- Genital Herpes
- Genital Warts
- Heavy Menstrual Flow
- Hysterectomy
- PMT
- Vaginal Thrush
- Are you pregnant? Yes NO

If yes, how many weeks? _____

Date of last menstrual period: _____

Do you take the contraceptive pill or HRT?
YES NO

Do you use an I.U.D? YES NO

Men

- Enlarged Prostate
- Genital Herpes
- Genital Warts

