Sharon Lunn LCPH, MCPH, RsHom, MARCH, RT
Registered Homeopath & Colon Hydrotherapist
Clinics at the Willow Herbal Centre, Romford & Wimpole, Cambridge
07932 553334 www.sharonlunn.co.uk www.colonicsessex.co.uk

Health Questionnaire (in strictest confidence)

Personal Details

Name & Title _____

Address _____

_____

Town/City/Village _____

County _____

Postcode _____

Telephone _____

E-Mail Address _____

Date of Birth _____ Age _____

Height (Metres) _____ Weight (Kg) _____

Occupation _____

Children (Number) _____ Ages _____

Blood Group _____

Your GP _____

GP's Address _____

_____

GP's Postcode _____

Your Health

Please note that if you need more space, there are continuation pages at the end of the form.

Have You Ever Had Antibiotics?

Please List

List Current Prescribed Medicines

List Current Vitamin/Mineral Supplements

List Food Allergies or Sensitivities

List Surgical Procedures in the Last Two Years

List Any Current Health Complaints or Illness

List Past Medical Problems with Approximate Dates

Please List any Family Health Conditions

Are you currently consulting any other health practitioners? Please provide details of treatments below.

Your Health (continued)

Do you or have you suffered from:

High or Low Blood Pressure	High ☐ Low ☐	Heart Disease	Yes ☐ No ☐
Kidney Failure	Yes ☐ No ☐	Cirrhosis of the Liver	Yes ☐ No ☐
Severe Haemorrhoids	Yes ☐ No ☐	Cancer of Colon or Rectum	Yes ☐ No ☐
Hernia	Yes ☐ No ☐	Recent Colon Surgery	Yes ☐ No ☐
G.I. Haemorrhage	Yes ☐ No ☐	Severe Anaemia	Yes ☐ No ☐
Perforation	Yes ☐ No ☐	Fissures/Fistulas	Yes ☐ No ☐

If you have answered 'Yes' to any of the above, please give details below

How often do you urinate daily?	3-4 times ☐		Less ☐	More ☐
Do you have any back pain?	Yes ☐	No ☐	How often?	
How regular are your bowel movements?				
Is there ever any mucous in your stools?				
Does stress affect your bowel movements?				
Do you crave any particular food? If so list below.				

Do you smoke?		If so, how many?	Per day
Do you drink?		How many units?	Per week

Tea or coffee ?			How many cups?		Per day		
With sugar?			How much?		Per cup		
Soft drinks; cola etc			How much?		Per day		
Glasses of water?			How many?			Per day	
Exercise frequency?	Per week		How long?		Per session		
Nightly sleep?	Hours		Sleep needed		Hours		
Is your appetite?	Good	☐	Moderate	☐	Poor	☐	
Do you frequently travel abroad?							
If yes, have you suffered with sickness or diarrhoea?							
Are you under a lot of stress at the moment?							
If so, do you know the cause? Please list below.							

Your Health (continued)

Please tick if you have suffered from any of the following:

General		Gastro-Intestinal	
Alcoholism	☐	Abdominal pain	☐
Amalgam fillings-how many	☐	Bad breath	☐
Anaemia	☐	Colitis	☐
Cancer (of any type)	☐	Constipation	☐
Chronic Fatigue Syndrome	☐	Cravings	☐
Diabetes	☐	Diarrhoea	☐
Dizziness	☐	Distension/abdominal bloating	☐
Double/blurred vision	☐	Diverticulitis/Diverticulosis	☐
Drug addiction	☐	Heartburn	☐
Fainting spells	☐	Indigestion	☐
Ear infections	☐	Irritable Bowel Syndrome	☐
Epilepsy	☐	Liver trouble (e.g. fatty liver)	☐
Headaches/Migraines	☐	Rectal bleeding	☐
Hepatitis	☐	Rectal itching	☐
HIV/Aids	☐	Ulcerative Colitis	☐
Hypoglycaemia M.E.	☐		
Weight loss	☐		
Over-active thyroid gland	☐		
Under-active thyroid gland	☐		
Gallstones	☐		

Cardio-vascular		Muscle & Joint	
Angina/Chest pain	☐	Arthritis	☐
Hardening of the arteries	☐	Low back pain	☐
Low blood pressure	☐	Joint pain/stiffness	☐
Rapid/irregular heartbeat	☐	Rheumatism	☐
Swelling of the ankles	☐	Muscle weakness	☐

Emotional/Nervous System		Skin	
Depression	☐	Bruise easily	☐
Fatigue	☐	Dermatitis	☐
Insomnia	☐	Eczema	☐
Irritability	☐	Fungal infections	☐
Lack of concentration	☐	Psoriasis	☐
Lethargy	☐		
Mood swings	☐		
Over-reacting	☐		
Panic attacks	☐		
Memory loss	☐		

Respiratory		Women	
Asthma	☐	Menorrhoea (absence of periods)	☐
Bronchitis	☐	Dysmenorrhoea (painful periods)	☐
Emphysema	☐	Endometriosis	☐
Hay fever	☐	Genital herpes	☐
Sinus problems	☐	Genital warts	☐
		Heavy menstrual flow	☐
		Hysterectomy	☐
		PMT	☐
		Vaginal thrush	☐
		Are you pregnant?	☐
		Date of last period	☐
		Are you on the Pill?	☐

Genito-urinary		Men	
Bladder infections	☐	Enlarged prostate	☐
Kidney infections	☐	Genital herpes	☐
Kidney stones	☐	Genital warts	☐

Lifestyle & Diet

Please give an indication of a typical daily diet

Breakfast				
Mid-Morning				
Lunch				
Mid-Afternoon				
Dinner				
Have you suffered from	Anorexia?	☐	Bulimia?	☐
Do you ever over eat?				
Are you	Vegetarian?	☐	Vegan?	☐
Do you feel that certain foods upset you?				☐
If so, please list below				
Any other relevant dietary information				

Please list your main reasons for wanting Colon Hydrotherapy

Additional information	
For questionnaire section	

Additional information
For questionnaire section

Declaration

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

Signed _____

Date _____

I agree to undergoing a rectal examination if, during conversation, it is deemed necessary.

Signed _____

Date _____