



Medical Questionnaire / Page One

All information provided is treated with the highest standard of confidentiality. The purpose of this questionnaire is for me to understand your overall health and well-being. If for any reason you do not wish to answer a question please leave it blank. Once completed, please bring it with you to your first appointment.

Name _____ Address _____

Date of birth _____ Postcode _____

Tel: (Home) _____ Date _____

Mobile _____ Height _____ Weight _____

Email _____ How many Children do you have? _____

Where did you hear of Osalo? _____

Name & address of GP _____

_____ Occupation _____

What is your reason for treatment? _____

Please list all medications you take _____

List past surgical procedures & dates _____

List any supplements you take _____

List any alternative treatments you are receiving _____

Please circle anything which accurately describes your bowel movements:

Spontaneous · Occur after eating · Effortless · Require straining/Painful · Incomplete feeling

How regular are your bowel movements? Please circle the most appropriate.

Once daily · 2/3 times daily · Every 2 days · Every 3/4 days · 5 days or more · Other

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Which best describes the appearance of your stools?

Fat Sausage · Skinny Sausage · Rabbit droppings · Pebbles · Loose · Diarrhoea

Do your stools mainly float or sink? _____

Are your stools smelly? YES / NO / SOMETIMES

How long have you had this pattern of bowel movements? _____

Have you taken antibiotics in the past? If so how often? _____

Do you have a family history of intestinal problems? YES / NO

If so, please specify? _____

Have you had a barium enema, colonoscopy or sigmoidoscopy? YES / NO

If so, what were the results? _____

Which best describes the condition of your skin? Dry · Combination · Sensitive · Oily · Dehydrated

Describe the condition of your nails: _____

Describe the condition of your hair: _____

Do you smoke? YES / NO If so how many per day? _____

Do you drink alcohol? YES / NO If so how much per day? _____

Do you drink tea / coffee? YES / NO

If so how much per day? _____ Are they caffeinated? YES / NO

Which best describes your urine? (Please circle as appropriate)

Clear · Very pale · Yellow · Dark yellow · Orange · Smelly

How much water / herbal teas / squash do you drink per day? _____ Litres / glasses

Do you exercise? YES / NO If so how often? _____

Do you take drugs or substances? YES / NO If yes, what? _____

Do you suffer from allergies / food sensitivities? OR do any foods make you feel bloated or tired? YES / NO

If so, please list here _____

Do you frequently travel abroad? YES / NO

Have you been treated for stomach upset / diarrhoea / parasites after travelling abroad? YES / NO

If yes, what was the treatment for? _____ And have the symptoms stopped? YES / NO

Are you under a lot of stress? YES / NO How do you relax or manage stress? _____

Daily diet

Please give an indication of a typical daily diet

Breakfast _____

Mid morning _____

Lunch _____

Mid Afternoon _____

Dinner _____

Are you vegetarian or vegan? YES / NO

Have you ever suffered from bulimia? YES / NO

Please give any other information that you think is relevant: _____

Digestive conditions

Please circle any problems that you are currently, or have experienced. 'N' = now 'P' = past condition

Fatigue after eating	N/P	Indigestion	N/P	Constipation	N/P
Griping / cramps	N/P	Ulcerative colitis	N/P	IBS	N/P
Ulcers	N/P	Haemorrhoids / Fissure	N/P	Diverticulitis / Diverticulosis	N/P
Liver problems	N/P	Cravings? Sugar / Salt	N/P	Gas / Bloating	N/P
Diarrhoea	N/P	Black Stools	N/P	Parasite infection	N/P
Crohn's disease	N/P	Perforation of gut	N/P	Abdominal Pain	N/P
Excessive flatulence	N/P	Vomiting of blood	N/P	Lactose intolerance	N/P
Reflux / heartburn	N/P	Anal itching / burning	N/P	Wheat Intolerance	N/P
Rectal bleeding	N/P	Gall bladder disease	N/P	Gluten Intolerance	N/P
Bad breath	N/P	Fissure / fistula	N/P	Dairy Intolerance	N/P
Candida	N/P				

Other conditions

Severe cardiac disease	N/P	Drug addiction	N/P	Cancer	N/P
Chronic fatigue syndrome	N/P	Multiple sclerosis	N/P	Migraine	N/P
Thyroid problems	N/P	Bronchitis	N/P	Sinus problems	N/P
Eczema	N/P	High blood pressure	N/P	STD	N/P
Diabetes	N/P	Dizziness	N/P	Rectal surgery	N/P
Hepatitis	N/P	Arthritis	N/P	Ear Infections	N/P
Acne	N/P	Fungal infections	N/P	Swollen joints	N/P
Cold hands and feet	N/P	Severe anaemia	N/P	HIV	N/P
Asthma	N/P	Alcoholism	N/P	Prostrate problems	N/P
M.E.	N/P	Low back pain	N/P	Epilepsy	N/P
Bruise easily	N/P	Psoriasis	N/P	Hay fever	N/P
Water retention	N/P	Eating disorder	N/P	Varicose veins	N/P
Kidney problems	N/P				

Nervous system

Anxiety	N/P	Depression	N/P	Headaches	N/P
Insomnia	N/P	Irritability	N/P	Fatigue	N/P
Mood swings	N/P	Lack of concentration	N/P		
Panic attacks	N/P	Overeating	N/P		

Womens issues

Heavy menstrual flow	N/P	Painful periods	N/P	Infertility	N/P
Miscarriage	N/P	Hysterectomy	N/P	Contraceptive pill	N/P
Vaginal thrush	N/P	PMT	N/P		
Irregular periods	N/P	Endometriosis	N/P		

Disclaimer

Colon hydrotherapy is not intended to replace the relationship with your primary health care providers and our consultation is not intended as a medical advice. They are intended as a sharing of knowledge and information from our education, research, and experience. The information and service provided is not used to prescribed, recommend, diagnose or treat a health problem or a disease. It is not a substitute for medical care. If you have or suspect you may have a health problem, you should consult your GP.

Please note any monies paid to Osalo Ltd for treatments are non refundable and must be taken within three months from the initial treatment.

Consent declaration

The information provided above is to the best of my knowledge true and accurate. The procedure for colon hydrotherapy has been explained and I hereby give my consent for a digital examination and colon hydrotherapy to be performed on myself today and all subsequent appointments.

Name _____

Signature _____ Date _____