



The Premier Detox and Health Assessment Centre for Ipswich

Medical questionnaire

All information provided is treated in the strictest confidence. The purpose of this is 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 ..... Date .....

Address .....

Postcode ..... E-mail .....

Tel: (Home) ..... Mobile .....

Date of birth ..... Age ..... Height ..... Weight .....

Occupation ..... Marital status: .....

How did you hear about Osalo? .....

Name & address of GP .....

How many children? ..... Describe your current health .....

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 any that are appropriate. My bowel movements are:

Spontaneous Occur after eating Effortless Require straining/Painful Incomplete feeling

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

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

What do your stools look like? Please circle any that are appropriate

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 the above pattern of bowel movements? .....

Have you taken antibiotics in the past? If yes how often? .....

Is there a family history of intestinal problems? YES / NO If yes, what? .....

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

If yes, when? And 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: .....



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### Digestive conditions

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

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

### Nervous system

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

### Women's issues

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



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Do you smoke? If yes how many per day? .....

Do you drink alcohol? If yes how much per day? .....

Do you drink tea / coffee/ cola? If yes how much per day? .....

If yes, are these drinks caffeinated? YES / NO

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

Clear Very pale Yellow Dark yellow Orange Smelly

How much water / herb teas / squash do you drink a day? ..... Litres/glasses

Do you exercise? How often? .....

Do you take drugs or substances? If yes, what? .....

Do you suffer from allergies / food sensitivities? OR Do any foods make you feel bloated or tired?

If yes, please list these: .....

.....

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? .....

.....

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 / NEITHER

Have you ever suffered from anorexia or bulimia? YES / NO

Please give any other information that you think is relevant:

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.....



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**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.

**Cancellation policy**

I understand that Osalo Limited have a cancellation policy which states that 24 hours cancellation is required for any appointment. Should I have an appointment on a Monday I understand I will need to cancel at the very latest on the previous Saturday before the equivalent time of my appointment on the Monday. If I cancel within 24 hours of my appointment as detailed above I understand I will be charged the cancellation fee of £50.00 or lose that part of my course of treatments unless Osalo is able to refill my cancelled appointment slot.

**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 .....