Questionnaire for The Milton Keynes and Northampton Colonic Clinic ©

(All information is treated in the strictest of confidence)

Date of initial consultation:
Practitioner:

Name: Date of birth:

Address: Telephone: Home
Work
Email

Height: Weight:

Does your weight vary much?
Occupation:
Previous occupations:
Place of birth:

1. Medical History

Have you ever had or do you have any of the following? (Tick for yes)

Migraines	Anaemia	IBS
Tinnitus	High/low blood pressure	Hernia–which type?
Hay fever	Skin problems	Colitis
Asthma	Rheumatism	Anal Fissures
Bronchitis	Gout	
Back problems	Arthritis	
Neuralgia	Haemorrhoids	
Ulcers	Diabetes	
Herpes	Gallstones	
Diverticulitis	Stomach problems	
Kidney problems	Cystitis	

2. **Current health**

Do you experience any of the following? (Tick for yes)

Flatulence	Heartburn
Indigestion	Nausea
Bloating	Constipation
Diarrhoea	Faeces which is to be a dark colour
Blood or mucus in your faeces	Faeces with a strong odour
Pain/difficulty having a bowel movement	Other digestive problems
Mucus or catarrh	Frequent colds
Cold sores	Cracked skin
Sensitive gums	Throat infections
Dizziness or light headedness	Runny or itchy eyes
Mouth ulcers or gum boils	

How often do you have a bowel movement?

How many times do you urinate each day?

3. **Stress**

Do you have low energy levels?

Do you have any sleeping difficulties?
If so – what are they?

(Tick for yes)

Poor short-term memory?	Confused thinking?
Over sensitivity to noise?	Overactive thinking?

Have you been/are you depressed?

4. **Medication**

Are you on any form of medication?

Please specify the name and how long you have been taking it/them. Also give details, including dosages where possible, of all vitamins and nutritional supplements used daily. Are these [ ] prescribed or [ ] self prescribed?

Have you ever taken any of the following medications for an extended period? If so say when and what for.

Antibiotics, steroids, cortisone, heart drugs, diuretics, any others.

5. **Family**

Are you: Single Married Widowed Separated Remarried

Sex and age of any children:

Who else lives at home with you?

6. **Food**

Please write down what you eat and drink on a typical day. Include quantity of fresh fruit and vegetables, meat and dairy produce. **How much plain water do you drink a day?**

Are you allergic/intolerant to any foods or drinks? Which ones?

Do you crave any of the following? (Please circle)

Sweet things Salty things Coffee Tea Nicotine

Chocolate Alcohol Anything else

Are there any foods or drinks you find it hard to digest? What are they?

Do you smoke? If so how many a day?

7. **Family history**

Have any of your parents, grandparents or brothers or sisters had any health problems?

8. **Operations**

Have you ever had any operations? Please state what the operation was for and the age you were at the time. Include all minor operations.

9. Write down all the exercise you have taken during the last week. Include all walking to work, frequent running upstairs, dancing. Gardening, as well as the more obvious activities such as sports, yoga etc.

10. What aspects of your health would you like to improve?

Women only

Do you currently have or have you ever had:

Pre-menstrual tension
Any problems with your periods
Menopausal symptoms
Cervical erosion
Pelvic inflammatory disease
Thrush or other vaginal discharge
Any sexually transmitted disease
Are you pregnant?

Men only

Have you ever had:

Thrush
Prostate problems
Any sexually transmitted disease
Cystitis
Vasectomy

11. Is there any other information that you feel may be relevant?

CANDIDA HEALTH CHECK

Tick all the questions that you answer 'yes' to and add up your score.

#	Question	Points
1.	Have you taken any antibiotics within the past year?	20
2.	Do you presently have any of the following symptoms: athlete's foot, jock itch or vaginitis?	20
3.	Do you have a sore or burning tongue?	20
4.	Do you have small white spots or patches in the mouth area, with swollen and sore tissue around them?	40
5.	Do you have almost continuous foul smelling lower intestinal gas?	20
6.	Do you have bloating and/or upper intestinal gas?	10
7.	Do you have indigestion frequently?	10
8.	Do you have severe insomnia?	20
9.	Do you wake up sweating at night?	10
10.	Do you have strong cravings for sweets or dairy products?	20
11.	Do you frequently get hives, rashes or itchy skin?	10
12.	Do you have a lot of allergies?	20
13.	Do you usually find it difficult to breathe through your nose?	10
14.	Do you feel sick all over and don't know the cause?	20
15.	Do you feel tired and fatigued all day?	20
16.	Do you feel severely depressed at times?	10
17.	Do you find your memory failing you frequently?	10
18.	Do you have disturbances with your vision?	10
19.	Do you crave alcoholic beverages?	10
20.	Does tobacco smoke really bother you?	10
21.	Do you have a loss of sexual drive?	10
22.	Do you have crying attacks?	10
23.	Do you have rectal itching or nasal itching?	10
24.	Do you frequently bite the insides of your cheeks?	10
25.	Do you feel a burning sensation when you urinate?	10

Your total score

If your score is less than 30 you probably don't have a Yeast Infection. You may want to consult your health care provider to help you assess the root cause of your condition.

Is your score over 30 but less than 50? Yeast Infection could be causing some of your health problems. Your condition may be *mild severity* with only minor physical symptoms such as food cravings or eye floaters.

Is your score between 50 and 90? You may have a *moderate severity* Yeast Infection with multiple conditions including discharges, itching, mood or emotional upsets.

Is your score over 90? A high score is a strong indication that you do have a Candida Albicans Yeast Infection. Your symptoms may also include depression, oral thrush, swollen tissue, discharges, foul odours, painful urination. Immediate action should be taken to get this serious health imbalance under control!

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

Signature ……

Date……..

I understand that colonic hydrotherapists do not give medical diagnosis or medical treatment. I agree to having a rectal examination if, during my appointment, it is thought to be necessary.

Signature……

Date……

Appointment notes

The Northampton and Milton Keynes Colonic Clinics.
0845 475 0606 & 01604 62966
www.colonicnorthampton.co.uk
www.miltonkeynescolonic.co.uk