Ashley Ager Dimech Colonic Hydrotherapist

Colonic Registration Form

PRIVATE and CONFIDENTIAL

Name: ............................................................................................................................................................................................................

Address: …………………………………….....................................................................................................................................

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Tel Home: .................................................................. Tel Work: ...............................................................................................................

E-mail: ..........................................................................................................................................................................................................

DOB: ....................................... Age: ..................

Have you previously had colonic hydrotherapy? Please give details, when, success etc ............................................................................

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What other therapies do you receive? …………….........................................................................................................................................

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Reason for wanting a colonic……………………………………………………………………………………………………………….

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Are you presently seeing a doctor?.................................................................................................................................................................

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Are you on any medication at present?..........................................................................................................................................................

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Are you taking any supplements?..................................................................................................................................................................

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What are your typical bowel movements? Frequency, amounts, colour etc?.................................................................................................

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Do you have any of the following? Cancer, diabetes, high BP, hepatitis/HIV/Aids, prolapse, thyroid disorder,

Heart disease, chron’s disease, ulcerative colitis…………………………………………………………………………………………….

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Do you: Drink alcohol YES/NO Tea YES/NO coffee YES/NO exercise YES/NO smoke YES/NO

 Do you have any of the following symptoms?

Diarrhoea Constipation Mucus in Stools Piles Gas

Heartburn/Indigestion Rectal itching Abdo pain Bloating General itching

Fungal infections Muscle aches and pains High/Low BP depression/Lethargy

Any other information you feel may be important for me to know:

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**Please be rest assured that any information given here will be treated in the**

**strictest confidence and will only be shared with a referring Health Care Practitioner with your consent**