Lavender Rooms The Organic Therapy Clinic
Client History Form

All information provided is treated in the strictest confidence. The purpose of this document 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……
Tel:
Home…….....Mobile…….....

Date of birth……..... Age…….....

Height…..…… Weight…….....

Occupation……Email address.....

How did you hear about Lavender Rooms?(please specify).....

Name & address of
GP.....

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

What is your reason for treatment?.....

Please list any medications/supplements that you take

…….....

List past surgical procedures &
dates…….....

.....

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

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?.....
Is there mucus in your stools? YES/NO Does stress affect your bowel movements? YES/NO

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

Have you ever taken laxatives?.....

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 conditions of your nails…… Describe the condition of your hair……

Digestive conditions

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

Fatigue after eating	N/P	Craving	N/P	Lactose intolerance	N/P
Indigestion	N/P	Gas/bloating	N/P	Reflux/heartburn	N/P
Constipation	N/P	Diarrhoea	N/P	Atonic colon	N/P
Gripping/cramps	N/P	Black stools	N/P	Rectal bleeding	N/P
Ulcerative colitis	N/P	Parasite infection	N/P	Spastic colon	N/P
IBS	N/P	Chrohn's disease	N/P	Anal itching/burning	N/P
Ulcers	N/P	Athlete's foot	N/P	Fissure/Fistula	N/P
Haemorrhoids	N/P	Abdominal pain	N/P	Bad breath	N/P
Diverticulosis/Diverticulitis	N/P	Excessive flatulence	N/P	Gall bladder disease	N/P
Liver problems	N/P	Vomiting of blood	N/P	Candida	N/P

Other conditions

Severe cardiac disease	N/P	High blood pressure	N/P	Severe Anaemia	N/P
Kidney problems	N/P	Rectal surgery	N/P	Prostate problems	N/P
Cancer	N/P	Diabetes	N/P	Asthma	N/P
Chronic fatigue syndrome	N/P	Dizziness	N/P	Alcoholism	N/P
Drug addiction	N/P	Ear infections	N/P	Epilepsy	N/P
Migraine	N/P	Hepatitis	N/P	M.E.	N/P
Thyroid problems	N/P	Arthritis	N/P	Low back pain	N/P
MS	N/P	Swollen joints	N/P	Hay fever	N/P
Sinus Problems	N/P	Acne	N/P	Bruise easily	N/P
Eczema	N/P	Fungal infections	N/P	Varicose veins	N/P
Bronchitis	N/P	HIV	N/P	Water retention	N/P

Nervous system

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

Women's issues

Absence of periods	N/P	Painful periods	N/P	Endometriosis	N/P
Heavy menstrual flow	N/P	Hysterectomy	N/P	Infertility	N/P
Miscarriage	N/P	PMS	N/P	Prolapsed womb	N/P
Vaginal thrush	N/P	HRT	N/P	Contraceptive pill	N/P
Irregular periods	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 Do you chew your food well? YES/NO

Which best describes your urine? Please circle as appropriate

Clear Very pale Yellow Dark yellow orange smelly

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

Do you exercise? YES/NO How often?.....

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 gone?.....

……

Are you under a lot of stress? YES/NO

How do you relax or manage stress? ……

……..

Daily diet

Please give an indication to 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

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Please give any other information that you think is relevant

……

……

……

……

Contraindications

If you have been diagnosed with any of the following complaints, you would not be a candidate for Colon Hydrotherapy treatments:

Abdominal hernia
Aneurysm
Blood Clots
Cirrhosis of the liver
Congestive cardiac failure
Colon, kidney or liver cancer
prostate problems
Rectal bleeding
Rectal Fissures
Renal insufficiency
Severe anaemia
Severe cardiac disease
Severe haemorrhoidsSevere
Recent colon or rectal surgery
Diverticulitis or Ulcerative Colitis (inflamed, medicated and suffering from symptoms)
Pregnancy

Disclaimer
Colon hydrotherapy is not intended to replace the relationship with your primary health care providers and the consultation is not intended as 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 prescribe, recommend, diagnose or treat a health problem or 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.

Consent declaration
The information provided above is to the best of my knowledge true and accurate. I have read and agree with the cancellation policy. 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. I have read the above and confirm that I do not suffer from any condition that may prevent me from receiving colon hydrotherapy. I will keep my therapist informed of any changes in my health.

Please note - Cancellation Policy
I realise that sometimes cancellations cannot be avoided, however, I do ask that you give 24 hours notice if should you need to cancel, this must be done by phone or the full treatment fee will be charged if you do not give 24 hours notice from the appointment time. Once you have scheduled an appointment, that time is put aside for you.

Signature…… Date……

Therapist signature……..

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