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Guildford, Surrey.  
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CASTLE STREET CLINIC  
Guildford Natural Health Centre

☎ Guildford (01483) 300400

Integrated Health Therapies  
Established 1996

Normandy Practice,  
Willow Cottage, Glaziers lane, Normandy,  
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☎ Local Call - 0845 260 21 22  
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**M J Rossetti** I-ACT, Dip SACH Hyp., ITEC, IHHT  
**Colon Hydrotherapy Questionnaire**  
*All information provided in this questionnaire  
will be treated in the strictest confidence.*

Full Name: .....

Address: .....

Telephone Number: (Home) ..... (Wk) ..... (Mob) .....

Date of Birth:..... Age:..... Sex: Male / Female Height:..... Weight:.....

Occupation: .....

Marital Status: Single/Married/Partner/Separated/Divorced/Widowed Do you have any children?.....

Name and Address of G.P: .....

Do I have your consent to contact your GP if necessary?.....YES / NO

Are you currently receiving medical treatment from your GP or hospital?.....YES / NO

If yes, please list condition(s) being treated: .....

Please list all medications you are taking: .....

List all past medical problems with approximate dates: .....

List all past surgical procedures with approximate dates: .....

List any vitamin/mineral supplements you are taking: .....

Are the above - PRESCRIBED / SELF-PRESCRIBED? How long have you been taking supplements? .....

Are you currently consulting any other practitioners? If so, please give details of the treatment you are receiving: .....

Please list any herbs and/or homeopathic remedies being used: .....

Do you suffer from, or have you ever suffered from:-

- |                                    |          |                                      |          |
|------------------------------------|----------|--------------------------------------|----------|
| High blood pressure .....          | YES / NO | Kidney failure .....                 | YES / NO |
| Heart disease .....                | YES / NO | Cirrhosis of the liver .....         | YES / NO |
| Severe Haemorrhoids .....          | YES / NO | Cancer of the Colon or Rectum .....  | YES / NO |
| Abdominal or Inguinal Hernia ..... | YES / NO | Recent colon or rectal surgery ..... | YES / NO |
| G.I. Haemorrhage/Perforation ..... | YES / NO | Severe Anaemia .....                 | YES / NO |
| Fissures/Fistulas .....            | YES / NO |                                      |          |

If you have answered YES to any of the above, please give details: .....

Please **CIRCLE** –

**C** if you Currently suffer, or  
**P** if you have suffered in the Past, or  
**P & C** if both in the past & currently suffer

from any of the following conditions:

**General**

Alcoholism	P	C
Anaemia	P	C
Cancer (of any type)	P	C
Chronic Fatigue Syndrome	P	C
Diabetes	P	C
Dizziness	P	C
Double/blurred vision	P	C
Drug Addiction	P	C
Fainting Spells	P	C
Ear Infections	P	C
Epilepsy	P	C
Headaches/Migraine	P	C
Hepatitis	P	C
HIV/Aids	P	C
Hypoglycaemia	P	C
M.E.	P	C
Loss of weight	P	C
Over active thyroid gland	P	C
Under active thyroid gland	P	C

**Cardiovascular**

Angina (Chest pain)	P	C
Hardening of the arteries	P	C
Low blood pressure	P	C
Rapid/irregular heart beat	P	C
Swelling of ankles	P	C

**Emotional/Nervous System**

Anxiety	P	C
Depression	P	C
Fatigue	P	C
Insomnia	P	C
Irritability	P	C
Lack of Concentration	P	C
Lethargy	P	C
Mood Swings	P	C
Nervous breakdown	P	C
Nervous exhaustion	P	C
Overeating	P	C
Panic attacks	P	C
Poor Memory	P	C
Schizophrenia	P	C

**Gastro-Intestinal**

Abdominal pain	P	C
Bad breath	P	C
Colitis	P	C
Constipation	P	C
Diarrhoea	P	C
Distension & bloating of abdomen	P	C
Diverticulitis / Diverticulosis	P	C
Excessive Flatulence	P	C
Gall bladder disease	P	C
Heartburn	P	C
Indigestion	P	C
Irritable bowel syndrome	P	C
Liver trouble	P	C
Rectal bleeding	P	C
Rectal itching	P	C
Ulcerative Colitis	P	C
Vomiting of blood	P	C

**Genito-Urinary**

Bladder infections	P	C
Kidney infections/stone	P	C
Painful urination	P	C
Recurring cystitis	P	C

**Muscle and Joint**

Arthritis	P	C
Low back pain	P	C
Joint pain/stiffness	P	C
Multiple Sclerosis	P	C
Muscle weakness	P	C
Swollen joints	P	C

**Respiratory**

Asthma	P	C
Bronchitis	P	C
Emphysema	P	C
Hay fever	P	C
Shortness of breath	P	C
Sinus problems	P	C
Tuberculosis	P	C

**Skin**

Acne	P	C
Bruise Easily	P	C
Dermatitis	P	C
Dryness	P	C
Eczema	P	C
Fungal infections	P	C
Itching	P	C
Psoriasis	P	C

**Women**

Abortion	P	C
Amenorrhoea (absence of periods)	P	C
Dysmenorrhoea (painful periods)	P	C
Endometriosis	P	C
Genital Herpes	P	C
Genital Warts	P	C
Heavy menstrual flow	P	C
Hysterectomy	P	C
Infertility	P	C
Miscarriage	P	C
PMT	P	C
Prolapsed womb	P	C
Scant menstrual flow	P	C
Too frequent periods	P	C
Vaginal Thrush	P	C

Are you pregnant?.....YES / NO

If yes, how many weeks? .....

Date of last menstrual period: .....

Do you take the contraceptive pill or HRT?.....YES / NO

Do you use an I.U.D.? .....

**Men**

Enlarged Prostate	P	C
Genital Herpes	P	C
Genital Warts	P	C
Impotence	P	C
Low sperm count/motility	P	C

Do you have a family history of any of the following conditions?

If YES please give brief details below -

Crohn's disease .....YES / NO  
Ulcerative Colitis.....YES / NO  
Heart disease.....YES / NO  
Cancer .....YES / NO  
Diabetes .....YES / NO  
Asthma.....YES / NO

.....  
.....  
.....  
.....  
.....  
.....

Do you smoke?.....YES / NO  
Do you drink alcohol? .....YES / NO  
Do you drink coffee? .....YES / NO  
Do you drink tea?.....YES / NO  
Do you drink water? .....YES / NO  
Do you drink soft drinks (cola etc.)? .....YES / NO  
Do you exercise?.....YES / NO  
Do you take recreational drugs?.....YES / NO

How many? .....  
How much? .....  
How many cups per day? .....  
How many cups per day? .....  
How many glasses per day? .....  
How many glasses per day? .....  
How often? .....  
What type and how often? .....

How regular are your bowel movements? .....

How many hours sleep do you need / get?.....

Do you have a good appetite? .....YES / NO

Do you suffer from any allergies / food sensitivities?.....YES / NO

If yes, please list .....

.....

.....

.....

Do you frequently travel abroad?.....YES / NO

Are you under a lot of stress?.....YES / NO

**Daily Diet**

Please give an indication of a typical daily diet

Breakfast: .....

Mid Morning: .....

Lunch: .....

Mid Afternoon: .....

Dinner: .....

Have you ever suffered from Anorexia or Bulimia?.....YES / NO

Are you Vegetarian or Vegan?.....VEGETARIAN / VEGAN / NEITHER

**Additional Information**

Please give any other information which you think is relevant: .....

.....

Main reason for wanting Colon Hydrotherapy: .....

Recommended by / saw advertisement: .....

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 / my child.

Signature: .....

Date: .....

