

Homefield Grange Retreat  
Manor Road, Rushton  
Northamptonshire NN14 1RH

Telephone Number: 01536 712219  
[www.homefieldgrangeretreat.co.uk](http://www.homefieldgrangeretreat.co.uk)

## Health Questionnaire

*In strictest confidence*

Full Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone number \_\_\_\_\_ (best to reach you on)

Email address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Occupation \_\_\_\_\_

Have you received any antibiotic treatment in the past six months? Yes  No

Marital Status Single  Married  Divorced  Separated  Widowed

Do you have any children? Yes  No  If yes, how old? \_\_\_\_\_

Current health complaints \_\_\_\_\_

\_\_\_\_\_

Please list any medications you are taking \_\_\_\_\_

\_\_\_\_\_

List all surgical procedures in the last two years \_\_\_\_\_

\_\_\_\_\_

Are you taking any vitamin/mineral supplements? Yes  No

If yes, are these prescribed  self-prescribed ?

If yes, please list \_\_\_\_\_

\_\_\_\_\_

How long have you been taking them? \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any family health conditions \_\_\_\_\_

How often do you urinate? 3-4 times a day  Less  More

Any back pain? Yes  No  How often? \_\_\_\_\_

How regular are your bowel movements? \_\_\_\_\_

Is there ever any mucous in your stools? Yes  No  \_\_\_\_\_

Does stress affect your bowel movements? Yes  No  \_\_\_\_\_

Do you crave any particular type of food? Yes  No  Please list \_\_\_\_\_

Do you smoke Yes  No  How many a day? \_\_\_\_\_

Do you drink alcohol Yes  No  How much a week? \_\_\_\_\_

Do you drink coffee Yes  No  How many cups per day? \_\_\_\_\_

Do you Add Milk Yes  No  Do you add sugar Yes  No

Do you drink tea Yes  No  How many cups per day? \_\_\_\_\_

Do you Add Milk Yes  No  Do you add sugar Yes  No

Do you drink soft drinks (cola etc) Yes  No  How many glasses per day? \_\_\_\_\_

Do you drink water Yes  No  How many glasses per day? \_\_\_\_\_

Do you exercise Yes  No  How often? \_\_\_\_\_

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

Do you ever overeat? Yes  No

Are you vegetarian or vegan? vegetarian  vegan  neither

Do you feel that certain foods upset you \_\_\_\_\_

Homefield Grange Retreat  
Manor Road, Rushton  
Northamptonshire NN14 1RH

Telephone Number: 01536 712219  
[www.homefieldgrangeretreat.co.uk](http://www.homefieldgrangeretreat.co.uk)

**Additional information**

Please give any other information you think relevant

---

---

---

---

---

---

List your main reasons for wanting colon hydrotherapy or wanting to do a detox

---

---

---

---

---

---

How did you hear about Homefield Grange Retreat

---

---

---

---

---

---

---

---

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

Signature

Date

---

I appreciate that colonic hydrotherapists do not give medical diagnosis or medical treatment. I agree to having a rectal examination if during discussion with my therapist it is deemed necessary.

Signature

Date

---

Please tick if you suffer, or have suffered, from any of the following conditions:

**General**

- Alcoholism
- Amalgam Fillings - How many
- Anaemia
- Cancer (of any type)
- Chronic Fatigue Syndrome
- Diabetes
- Dizziness
- Double/Blurred Vision
- Drug Addiction
- Fainting Spells
- Ear Infections
- Epilepsy
- Headaches/Migraines
- Hepatitis
- HIV/Aids
- Hypoglycaemia
- M.E.
- Loss of Weight
- Over Active Thyroid gland
- Under Active Thyroid Gland
- Other

**Cardiovascular**

- Angina (Chest Pains)
- Hardening of the Arteries
- Low blood pressure
- Rapid/Irregular heart beat
- Swelling of the ankles
- Other

**Emotional/Nervous System**

- Anxiety
- Depression
- Fatigue
- Insomnia
- Irritability
- Lack of concentration
- Lethargy
- Mood Swings
- Over Reacting
- Panic Attacks
- Poor Memory

**Respiratory**

- Asthma
- Bronchitis
- Emphysema
- Hay Fever
- Sinus Problems

**Genito-Urinary**

- Bladder Infections
- Kidney Infections/Stone
- Other

**Gastro-Intestinal**

- Abdominal pain
- Bad Breath
- Colitis
- Constipation
- Craving
- Diarrhoea
- Distension & Bloating of Abdomen
- Diverticulitis /Diverticulosis
- Heartburn
- Indigestion
- Irritable Bowel Syndrome
- Liver Trouble
- Rectal Bleeding
- Rectal Itching
- Ulcerative Colitis
- Other

**Muscle and Joint**

- Arthritis
- Low Back Pain
- Joint Pain/Stiffness
- Muscle Sclerosis
- Muscle Weakness
- Other

**Skin**

- Acne
- Bruise Easily
- Dermatitis
- Eczema
- Fungal Infections
- Psoriasis

**Women**

- Amenorrhoea (Absence of Periods)
- Dysmenorrhoea (Painful Periods)
- Endometriosis
- Genital Herpes
- Genital Warts
- Heavy Menstrual Flow
- Hysterectomy
- PMT
- Vaginal Thrush
- 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? YES  NO

**Men**

- Enlarged Prostate
- Genital Herpes
- Genital Warts

