RICTAT
International Colonic Association
Trusted Provider
www.rictat.org

Name:

Date of Birth:

Address & Postcode:

Email Address:

Occupation:

Telephone Number:

GP name and/or Surgery Name:

Do you have any health or medical conditions? No Yes
Details:

Are you taking any medication? No Yes
Please state what you are taking and why:

Are you seeing your GP at present? No Yes
Details:

Are you undergoing any investigations from your GP or hospital? No Yes
Details:

Have you ever had any surgical procedures? No Yes
Please state what procedures and when:

Have you been discharged from all surgical procedures? No Yes

Are you awaiting any test results? No Yes

Do you have any allergies? No Yes
Details:

Do you have any infectious diseases? No Yes
Details:

Are you taking/using any fat loss medication or injections? No Yes

Are you taking any supplements at present?
Details: No Yes

Have you ever fainted or felt faint on the toilet?
Details: No Yes

Have you been diagnosed with any type of prolapse?
Bladder, Bowel Uterus, Other
Details: No Yes

Do you have any Kidney Disease or reduced Kidney function? No Yes

If so, is it less than 50% overall and/or any fluid restrictions? No Yes

Do you suffer from any of the following conditions or have you had any procedures listed below:

Abdominal Surgery in the last 6 months No Yes
Atrial Fibrillation No Yes
Any form of Hernia No Yes
Autonomic Dysreflexia No Yes
Bowel Obstruction No Yes
Bowel biopsy in last 3 months No Yes
Cancer No Yes
(If so, please give details)
Undergoing Chemotherapy No Yes
Bowel or Colon Surgery No Yes
Diabetes No Yes
Severe Persistent Diarrhoea No Yes
Epilepsy No Yes
Ehlers Danlos Syndrome No Yes
Gastric Band, Sleeve, Bypass, Balloon or other No Yes
(If so, please give dates and if discharged)
Heart Failure No Yes
Any Heart Condition No Yes
Uncontrolled High Blood Pressure No Yes
Inflamed, Bleeding Haemorrhoids (Piles) No Yes
Inflammatory Bowel disease No Yes
Colitis No Yes
Ulcerative Colitis No Yes
Crohn’s Disease No Yes
Diverticulosis/Diverticulitis No Yes
Please give detail

Intussusception No Yes
Laparoscopic Surgery or Investigation last 8 weeks No Yes
Liver Disease or Impaired Liver Function No Yes
Are you Pregnant No Yes
Prostatitis No Yes
Prostate Biopsy in the last 3 months No Yes
Radiotherapy of Abdominal Area in the last 2 years No Yes
Rectal Bleeding No Yes
Active Rectal Fissure No Yes
Rectal Fistula No Yes
Rectal Surgery No Yes
POTS/Tachycardia No Yes
Do you have any other medical condition or health problem or condition not listed above?
If so, please give details: No Yes
Have you had any Hip/Shoulder/Knee joint surgery No Yes
In the last 6 months? Have you been diagnosed with Irritable Bowel Syndrome No Yes
Do you suffer with:
Constipation No Yes
Bloating No Yes
Diarrhoea No Yes
Gas/Wind No Yes

General Bowel Movements
How often do you have a bowel movement E.g. Daily, 2X weekly, weekly,
please state:

Have you given birth in the last 2 years? No Yes
If yes please state if Natural or Caesarean?

Are you Breastfeeding? No Yes

Have you had a hysterectomy? No Yes
Details:

Do you smoke/vape? No Yes
If so how many a day?

Do you drink alcohol? No Yes
If so how many units a week?

Do you drink water? No Yes
How much a day?

Do you follow any special diet? No Yes
Give details

Please read and sign your declaration in order to proceed with your treatment:

I declare the information I have given is correct and complete. I agree to undergo a possible rectal examination and subsequent colon hydrotherapy treatment and to receive enema herbs as part of my treatment if recommended by my therapist.

I understand there is no guarantee that a colonic can empty my colon. Colonics involve using warm purified water to gently stimulate the colon to empty itself using the natural peristaltic action of your colon. We don't 'suck' or 'pump' waste material out, therefore what comes out depends on what is in there and what your body releases. Treatment results vary from person to person. Your therapist does not diagnose disease, or prescribe medication.
Should any of your responses to any of the above questions contraindicate colon hydrotherapy you will be advised to seek your GP/Dr's advice.
It is your responsibility to provide full and complete answers so that your therapist can treat you correctly and appropriately.
You must inform us of any changes to your health and medication between treatments. Please make your therapist aware, before your treatment, if there are any conditions listed above that you do not understand enough to offer informed consent for your treatment.

Please note, you must sign (type is fine), and enter your full name for the form to be valid.

Signed:

Full Name:

Therapist: Danielle Parkinson

Date:

General Data Protection Regulations (GDPR)

I consent to the data I have given to be used for the purposes of documentation and communication in regards to the treatment I am undertaking. I understand the data and information on paper copies will be stored securely and any data stored on electronic devices will be password protected. Only information relating to my treatment will be held and will be stored for no longer than necessary. My data will not be passed to any third party without my consent.

I am happy to receive any information on promotions and or newsletter
I consent to being contacted by:

Email	Y N
Telephone	Y N
Text/Message	Y N

Signed:
Date:

For Therapist Use: Any updates disclosed during treatment? Yes No

SOP sheets completed: Yes No

Signature: