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? Details:	No	Yes
Are you taking any medication? Please state what you are taking and why:	No	Yes
Are you seeing your GP at present? Details:	No	Yes
Are you undergoing any investigations from your GP or hospital? Details:	No	Yes
Have you ever had any surgical procedures? Please state what procedures and when:	No	Yes
Have you been discharged from all surgical procedures?	No	Yes
Are you awaiting any test results?	No	Yes
Do you have any allergies? Details:	No	Yes
Do you have any infectious diseases? Details:	No	Yes
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? If so, is it less than 50% overall and/or any fluid restrictions?	No No	Yes 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	
	No	Yes	
Inflammatory Bowel disease			
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?	No	Yes

If so, please give details:

Have you had any Hip/Shoulder/Knee joint surgery In the last 6 months?	No	Yes
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

Declaration:

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.

Signed:

Name:

Therapist:

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	Yes	No
Telephone	Yes	No
Text/Message	Yes	No

Signed:

Date:

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

Signature:

SOP sheets completed: Yes No