Complete Health

COLON HYDROTHERAPY INTAKE FORM

NAME_____ DATE_____ BIRTH DATE_____

ADDRESS_____CITY _____ ST __ ZIP_____

HOME PHONE_____WORK PHONE_____EMAIL_____

OCCUPATION_____REFERRED BY_____

SEX_____HT_____WT_____ ARE YOU CURRENTLY PREGNANT? Y N MONTHS: _____

CHILDREN_____MISCARRIAGES/ABORTIONS_____

DO YOU HAVE ANY ALLERGIES TO FRAGRANCES OR TOPICAL PREPARATIONS?_____

ARE YOU CURRENTLY UNDER MEDICAL TREATMENT? __If Yes, FOR WHAT CONDITIONS?_____

PLEASE LIST YOUR DOCTOR'S NAME AND NUMBER: _____

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?

___ADD/ADHD
___ADRENAL FATIGUE
___ALLERGIES
___ANEMIA
___ANXIETY
___APPENDICITIS
___ARTHRITIS
___ASTHMA
___AUTOIMMUNE DISEASE
___BACKACHE: UPPER MID LOWER
___BAD BREATH
___BLOOD IN STOOL
___CANCER
___CANDIDIASIS
___CARDIAC PROBLEMS
___CHEMICAL SENSITIVE
___CHEMOTHERAPY
___CHRONIC FATIGUE
___COLITIS
___CONSTIPATION
___CROHN'S DISEASE
___DEPRESSION
___DIABETES
___DIARRHEA
___DIVERTICULITIS
___ECZEMA
___FIBROIDS
___FIBROMYALGIA
___GALL BLADDER PAIN
___GALL STONES
___GASTRITIS
___HEADACHES
___HERNIA
___HIGH BLOOD PRESSURE
___HYPER/HYPOTHYROID
___INDIGESTION
___IRRITABLE BOWEL (IBS)
___KIDNEY PROBLEMS
___LEAKY GUT SYNDROME
___LIVER DISORDERS
___LOW BLOOD PRESSURE
___MUCUS IN STOOL
___POLYPS
___PARASITIC INFECTION
___PROSTATE PROBLEMS
___PMS
___PSORIASIS
___RECTAL/ANAL BLEEDING
___RECTAL/ANAL PAIN
___RESPIRATORY INFECTION
___SKIN CONDITIONS
___SURGERY
___SYNCOPE (FAINTING)
___ULCER

___HEMORRHOIDS INTAKE: CURRENT OR PAST
___ALCOHOL
___ANTACIDS
___ANTIBIOTICS
___ASPIRIN/IBUPROFEN
___BLACK TEA
___COFFEE: ____CUPS/DAY
___DAIRY
___DRUGS (RX OR REC.)
___GREEN LEAFY VEGGIES
___MEAT: WHITE RED
___SODA
___SUGAR
___WATER: ____CUPS/DAY
___WHEAT

PLEASE DESCRIBE IN FURTHER DETAIL ANYTHING CHECKED ABOVE:

_____

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT? (INJURIES, ILLNESSES, ACCIDENTS, ETC.)

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COLON HYDROTHERAPY INTAKE FORM (Cont'd)

HAVE YOU EVER RECEIVED A COLONIC BEFORE?_____IF SO, WHEN?_____

RESULTS_____

DO YOU OR HAVE YOU EVER TAKEN LAXATIVES? Y N HOW OFTEN?_____
TYPE: _____RESULTS_____

HAVE YOU EVER DONE AN HERBAL CLEANSE? Y N IF SO, WHICH ONE(S)?_____
RESULTS_____

HAVE YOU EVER FASTED? TYPE: JUICE LIQUID WATER OTHER_____
FOR HOW LONG?_____ RESULTS_____

BOWEL MOVEMENTS: #/DAY_____ OR #/WEEK_____

COLOR (circle): DARK BROWN LIGHT BROWN YELLOW BLACK RED GREY OTHER_____

ODOR: NONE SWEET SHARP PUTRID APPROX. LENGTH_____ DIAMETER_____

TEXTURE: SOFT HARD SMOOTH FLAKY BRAIDED LOOSE 'RABBIT PELLETS'

OTHER_____ DEFECATION IS: EASY HARD PAINFUL SHORT LONG RARE

FOOD IN STOOL? Y N IF SO, WHAT FOODS?_____

WHAT DOES YOUR DAILY DIET CONSIST OF?_____
_____

CRAVINGS? Y N _____ DO YOU EAT LATE AT NIGHT? Y N

SLEEP: HRS/NIGHT_____ BEDTIME_____DO YOU AWAKE FEELING RESTED?_____

EXERCISE: HOW OFTEN_____WHAT TYPE(S)_____

BLOOD PRESSURE_____PULSE RATE_____CHOLESTEROL COUNT_____ BLOOD TYPE_____

DO YOU RECEIVE NATUROPATHIC CARE? Y N MASSAGE? Y N TYPE(S):_____

ACUPUNCTURE/ORIENTAL MEDICINE? Y N ORIENTAL DIAGNOSIS:_____

WHICH DO YOU EXPERIENCE MOST OFTEN: JOY SADNESS FEAR WORRY ANGER RAGE

PAIN JEALOUSY SHAME GUILT DISDAIN APATHY OTHER_____

WHAT WOULD YOU LIKE TO FEEL MOST OFTEN?_____

WHAT ARE THE CURRENT STRESSORS IN YOUR LIFE?_____

WHAT ACTIVITIES HELP TO RELIEVE STRESS FOR YOU?_____

WHAT IS YOUR REASON FOR COMING HERE TODAY?_____

WHAT IS YOUR GOAL FOR THE SESSION?_____

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COLON HYDROTHERAPY INTAKE FORM

*** * * CONTRAINDICATIONS * * ***

A *contraindication* is any indication or symptom that makes it inadvisable to use a particular therapy.

Absolute contraindications prohibit treatment altogether. For example, colon hydrotherapy is absolutely contraindicated for patients with pronounced rectal bleeding. Relative contraindications involve a risk/benefit ratio. In the case of colon cancer, colon hydrotherapy's ability to eliminate poisonous toxins is evaluated against possibly weakening the already-compromised colon walls.

The following are **absolute contraindications** for colon hydrotherapy. If you have any of these, colon hydrotherapy is **NOT** advised. Once they have subsided or been eliminated, colon therapy may be indicated.

Abortion (less than 6 months)
Anal Fissure/Fistula (a tear in the colon)
Anemias (Severe)
Aneurysm
Cirrhosis
Colon Cancer (see below)
Colon Surgery (less than six months post-op: see below)
Colostomy
Crohn's disease (in the acute inflammatory or bleeding stages)
Epilepsy
GI Hemorrhage/Perforation
Heart Disease(Severe, Uncontrolled Hypertension; Congestive Heart Failure)
Hemorrhoids (severe or bleeding [minimal bleeding is okay])
Hernia (abdominal/inguinal)
History of seizures
Kidney Dialysis
Miscarriage (less than 6 months)
Pregnancy (up to 4 months)
Recent heart attack
Rectal Bleeding (except for minor hemorrhoids)
Renal Insufficiency
Tumor in the Rectum or Large Intestine
Ulcerative colitis (active or bleeding)

*The following are **relative contraindications** for colon hydrotherapy. A physician prescription is necessary.*

Crohn's Disease
Acute Colitis
Severe Diverticulosis / Acute Diverticulitis
Colon Cancer (need MD approval on integrity of colon)
Colon Surgery (need MD approval on integrity of colon)

Please know that insurance does NOT generally cover colon therapy treatments.

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COLON HYDROTHERAPY INTAKE FORM

CLIENT AGREEMENT

I understand that the therapist does not diagnose, treat or prescribe for any illness, ailment or disease and does not do any spinal manipulations. While the therapist may assist me in relief of physical or emotional symptoms, I understand that it is not the function of the therapist to try to cure me and that I am responsible for my own body, feelings and emotions. It is clear to me that colon hydrotherapy is not a substitute for medical examinations or diagnosis and that it is recommended that I see a physician for any physical ailment.

It is understood that colon hydrotherapy is a safe and therapeutic form of cleansing, hydrating and detoxifying the colon. The focus and intent of this work is wellness of body. Control of the session is mine. I will feel free to comment on the comfort or discomfort of the session at any time.

I can say "Stop" at any time during the session.

I agree not to eat or drink two hours before the session and to be free of alcohol and recreational drugs.

In consideration of people with allergies to fragrances, I agree to refrain from using scented products on the day of my treatment.

I understand that I will be fully covered with a sheet or blanket at all times when unclothed and only the part of my body being addressed, will be uncovered.

I am aware that this is a non-sexual treatment. Any misconduct or inappropriate behavior in this area will result in the immediate termination of the session with full payment due.

If I am late for an appointment I understand my time may be shortened as a result.

Twenty-four hours' notice is required for cancellation of an appointment by me or by the therapist. If the therapist fails to give me a 24-hour cancellation notice, the next session will be provided free of charge. If I fail to give 24 hours' notice or fail to keep an appointment, I will be responsible for the full cost of the session.

I agree to pay by check, cash or credit card before or after the session.

If my check does not clear, I agree to pay a $25 service fee, as well as any additional charges the therapist may incur as a result.

I, THE UNDERSIGNED, ACKNOWLEDGE THAT OUR CERTIFED COLON THERAPIST, WILL NOT PRESCRIBE (ORDER FOR USE AS MEDICINE) AND I, THE UNDERSIGNED, WILL NOT HOLD HER ACCOUNTABLE FOR SUCH. THE THERAPIST IS HELPING ME WITH NATURAL HYGIENE AT MY REQUEST, AND IS NOT DIAGNOSING NOR TREATING DISEASE, NOR PRACTICING ANY FORM OF MEDICINE.

Date: _____ _____

CLIENT'S SIGNATURE

Notice Designed to comply with the State of California Guidelines in The Business and Professions Code of the State of California: Section 2053.6

***** All clients must read, understand, and sign this disclosure *****

Colon Hydrotherapy services provide at this center complies with Section 2053.6 to the Business and Professions Code of the State of California. In compliance with the Code, you must be advised:

A) There are NO licensed physicians at this center and the individual performing colon hydrotherapy is ONLY a Colon Hydrotherapist, they are not a physician. This means and implies that they cannot and will not:

1. Conduct surgery or any other procedure on another person that punctures the skin or harmfully invades the body.
2. Administer or administer X-ray radiation to another person.
3. Prescribe or administer legend drugs or controlled substances to another person.
4. Recommend the discontinuance of legend drugs or controlled substances prescribed by an appropriately licensed practitioner.
5. Willfully diagnose and treat a physical or mental condition of any person under circumstances or conditions that cause or create a risk of great bodily harm, serious physical or mental illness, or death.
6. Set fractures.
7. Treat lacerations or abrasions through electrotherapy.
8. Hold out, state, indicate, advertise, or imply to a client or prospective client that he or she is a physician, a surgeon, or a physician and surgeon.

B) Colon Hydrotherapy is alternative or complementary to healing arts services licensed by the state.

C) The services of Colon Hydrotherapy and the Therapist that provide the services are not licensed by the state.

D) The session of Colon Hydrotherapy includes the following procedures:

1. The client will insert and retract the speculum.
2. Warm (temperature and pressure controlled) water will flow into the colon softening the fecal material, which will be released through normal peristalsis into the sewer.
3. Your dignity and modesty will be maintained at all times.
4. The session will last approximately 30-45 minutes.

E) The theory of treatment upon which Colon Hydrotherapy is more historical and intuitive than scientific as there have not been any studies to validate the effectiveness of the modality. However, many cultures and societies believe that a clean colon can enhance the health of the individual. This started thousands of years ago with the simple enema and has evolved into the present day colonic. Many people simply report they feel better after a Colonic. On the other hand, there is a growing number of health care practitioners that believe in the concept of auto-intoxication, That a sluggish bowel (one that is not regular) allows the body to reabsorb toxins from the colon. his theory may or may not have validity depending on who you listen to, but we know there is increased level of toxins in our environment and common sense tell us that anything we can do to assist the body of ridding itself of toxins should have some value.

F) All therapists working at From Within Colon Health have been trained and follow the I-ACT Guidelines.

I acknowledge that I have read the about disclosure and have been given a copy of the document. This information was provided to me in language I can read and understand.

_____ _____

Client Signature Date

Print Name:_____

INFORMED CONSENT

TO: Complete Health an Acupuncture Corporation

I _____, hereby represent that I have been informed that
(client's name)
Teresa Rispoli is not a medical doctor, therefore, I do not expect a physical examination, diagnosis, prescription, prognosis nor any of those things usual with a Doctor of Medicine.

I have been advised that Teresa Rispoli has her Ph.D. in Nutrition. She Is a Licensed Acupuncturist and Oriental Medicine Pracitoner. She is a Board Certified, Endermologist and has a Masters in Naturopathy.

I understand that Teresa Rispoli is involved with building health, not treating disease. Her involvement is to teach me health and preventative measures to maintain my good health. Her efforts will be aimed at education, non-invasive testing to determine vitamin, mineral or other imbalances in my body. She may incorporate, diet, exercise physiology, lifestyle counseling, motivational therapy, herbology and other approved modalities as deemed necessary and with my approval. I am requesting education and actual assistance in health measures under my correct name (legal name) and I am in fact, requesting Teresa Rispoli to aid me in obtaining optimum health. I have been informed of the risk and or side effects, if any, associated with supplements and I hereby acknowledge my informed consent to said therapy and or supplements.

I declare under penalties of perjury, under the laws of the state of California, that I am not now, or have I ever been in the employ of any city, county, state or government agency trying to entice and entrap you into practicing medicine without a license, and I am not seeking information under cover or false identity or misrepresentation of my situation. I waive all rights of immunity from seeking information under cover of government agency or agencies.

I promise to provide any and all information with regards to my health including, but not limited to, pre-existing conditions, surgeries or diseases.

I am requesting health related services and/or products from you without having received from you any oral or written promise that these health products or services will have health benefits for me in the treatment of any disease or condition I may have. I hereby agree to release and hold Teresa Rispoli harmless from any and all liability claims, damages or causes of action arising from or related to pre-existing conditions which I have.

I understand that herbal supplements are a form of food therefore provide nutrition and not intended as medical advice or replacement for medical treatment. Please consult your medical professional.

I understand that a 24 hour notice of cancellation is required or I will be charged the full cost of the treatment. I have read the foregoing and voluntarily consent to the terms and conditions contained herein. I understand that there is a charge for the consultation and a no refund policy in effect.

_____ _____

Client's Signature Date

HIPAA Compliance and Consent Form

The Undersigned:

Patient:_____

Born on: _____

Resident of: _____

On April 14th, 2003 the new federal Health Insurance Portability and Accountability Act (HIPAA or "the Act") became effective. The stated purpose of the Act is to protect the confidentiality and security of your health information through a number of different privacy standards. Our facility will do everything in its power to abide by the HIPAA regulations and respect the privacy of your name and your medical information. We agree to refrain from using your name as a referral without your express written consent. We will use our best efforts to keep your name and your medical information confidential.

We occasionally e-mail out appointment reminders, newsletters, and special offers to our clients. If you consent to receiving these communications by e-mail, please indicate by signing the consent form below. Please let us know if you have any questions. Thank you.

I have read and understand this HIPAA compliance and consent form. I hereby give my consent to the facility to send me appointment reminders, greeting cards, special offers, and newsletters via e-mail. I do **not** give my consent to having my names used as a reference unless otherwise indicated.

_____ _____

Client Signature Date

_____ _____

Witness Date