

CLIENT INFORMATION & MEDICAL HISTORY

COLON HYDROTHERAPY

PERSONAL HISTORY

Client Name: _____ Today's Date: _____

Home Address: _____ City: _____ State _____ Zip _____

Home Phone(____) _____ Work Phone (____) _____ Mobile (____) _____

Date of Birth: _____ Age: _____ Occupation: _____

Height _____ Weight _____ Female _____ Male _____ Marital Status _____

Emergency Contact Name and Phone _____

How were you referred to us? _____

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, for what? _____

Do you have a prescription for this visit? _____ If yes, do we have a copy on file? _____ If yes, Date _____

Is Colon Hydrotherapy part of a protocol that a healthcare professional has referred or prescribed for you? ☐ Yes ☐ No

If yes, Doctors and Type of Doctor _____

Reason _____ Date of referral/prescription _____

Do you have any of the following medical conditions? Please check all that apply:

☐ Abdominal Hernia	☐ Abdominal Surgery	☐ Abnormal Distension	☐ Acute Liver Failure
☐ Anemia	☐ Aneurysm-All Types	☐ Cancer of the Colon	☐ Cardiac Condition
☐ Crohns Disease	☐ Colitis	☐ Dialysis Patient	☐ Diverticulitis
☐ Fissures & Fistulas	☐ Hemorrhaging	☐ Hemorrhoidectomy	☐ Intestinal Perforations
☐ Lupus	☐ Pregnant	☐ Rectal/Colon Surgery	☐ Renal Insufficiencies
☐ Irritable Bowel Syndrome	☐ AIDS	☐ Diverticulosis	☐ Bladder Infections
☐ Bloating	☐ Blood in Stool	☐ BM Difficult	☐ Itching Anus
☐ Constipation	☐ Diarrhea	☐ Infectious Disease	☐ Hemorrhoids
☐ Colonoscopy	☐ Rectal Bleeding	☐ Hepatitis B or C	☐ Parasites

Do you have any communicable Disease? ☐ Yes ☐ No If yes, explain: _____

Do you have any other health problems or medical conditions: Please list: _____

MEDICATIONS & SUPPLEMENTS

List all you now take regularly including over the counter: _____

Do you take digestive aids/laxatives? ☐ Yes ☐ No If yes, describe: _____

Are you on any steroids? ☐ Yes ☐ No Injections/oral _____

Are you on any blood thinners? ☐ Yes ☐ No Are you on any diuretics? ☐ Yes ☐ No

What was the most recent time you took antibiotics? _____ Why? _____

ADDITIONAL INFORMATION:

Describe your regular routine for exercise: _____

On a scale of 1 to 10 where 1 = can't get out of bed and 10=optimal energy, describe your normal energy level: _____

How many servings of vegetables do you eat per day? _____ How many servings of fruit per day? _____

How much water do you drink per day? _____

How much dairy do you eat per day? _____ How much meat do you eat per day or week? _____

Do you smoke? ☐ Yes ☐ No If yes, how much and how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how long? _____

How often do you have a bowel movement? _____ skips days _____ 1 per day _____ 2 per day _____ 3 per day

Color and consistency of bowel movement _____

What do you hope to achieve from this colon hydrotherapy appointment? _____

Do you have specific concerns? ☐ Yes ☐ No If yes, explain: _____

My signature below indicates that I have honestly answered all of the questions above and supplied any additional relevant information within this intake form.

_____ Date: _____

Client Name (Printed clearly)

Client Signature

COLON HYDROTHERAPY/COLONIC INFORMED CONSENT

I, _____, have decided to undergo a Colon Hydrotherapy/Colonic procedure.

A Colonic is intended to clean the colon by removing build up in the large intestine. The colon is filled and emptied with filtered water either warm or cold. I understand that there may be benefits resulting from this procedure, however, I understand and agree that no warranties have been made as to the effectiveness or outcome of this procedure.

I understand that either the colon hydrotherapy technician or I will insert a tube into my colon, and agree that I will witness the technician using sterile and new instruments. Following the procedure I will witness the proper disposal of the nozzle that was used.

The possible side effects of Colon Hydrotherapy include but are not limited to:

1. Perforation of colon, the risk of which increases with age and I agree that I am not over the age of 65. _____ Initial
2. Allergic reaction to nozzle _____ Initial
3. Electrolyte imbalance. In order to lessen the risk of this complication I agree to use the probiotic supplement the facility/technician has provided _____ Initial
4. Infection from contaminated equipment _____ Initial

I understand that Colon hydrotherapy should be avoided by people suffering from diverticulitis, Crohn's disease, ulcerative colitis and severe tumors or hemorrhoids in the rectum. It should also be avoided soon after a bowel surgery. People suffering from kidney or heart problems should also avoid regular colon hydrotherapy. People suffering from bowel, anal or rectal pathologies should avoid colon hydrotherapy because the pathology may contribute to the risk of bowel perforation.
_____ Initial

I understand that certain medical treatments may have adverse effects on persons of a young age and agree that I am not under the age of 18. _____ Initial

I confirm that I am not a woman who is pregnant, nursing or trying to become pregnant as this would make me an unsuitable candidate for this procedure. _____ Initial

This list is not meant to be inclusive of all possible risks associated with colon hydrotherapy as there are both known and unknown side effects associated with any medication or procedure.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent for this colon hydrotherapy treatment and release the doctor, the person performing the colonic and the facility from liability associated with this and all subsequent treatments with the above understood.

Client Signature _____ Date: _____