Purify Colonics & Wellness: Colonic Intake Form

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_

Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why are you interested in colonics?

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**CONTRAINDICATIONS\***

***A contraindication is a specific health condition in which a drug, procedure, treatment, or surgery is inadvisable, as it may be harmful to the health of the patient.***

Please **WRITE THE DATE** if you have had any experience with the following health issues:

Abdominal Hernia\_\_\_\_\_\_\_ Abdominal Surgery\_\_\_\_\_\_\_ Abnormal Bowel Distention\_\_\_\_\_\_\_

Acute Liver Failure\_\_\_\_\_\_\_ Anemia\_\_\_\_\_\_\_ Aneurysm\_\_\_\_\_\_\_ Cancer (type:\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_

Cardiac Condition\_\_\_\_\_\_\_ Crohn’s Disease\_\_\_\_\_\_\_ Colitis\_\_\_\_\_\_\_ Kidney Disease/Dialysis\_\_\_\_\_\_\_

Diverticulosis/Diverticulitis\_\_\_\_\_\_\_ Anal Fissures/Fistulas\_\_\_\_\_\_\_ Hemorrhages (internal/external)\_\_\_\_\_\_\_

Hemorroidectomy\_\_\_\_\_\_\_ Intestinal Perforations\_\_\_\_\_\_\_ Lupus\_\_\_\_\_\_\_ Rectal/Colon Surgery\_\_\_\_\_\_\_

Renal Insufficiencies\_\_\_\_\_\_\_

Are you or could you be pregnant? Please circle: Yes or No If yes, due date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Colonics are* ***NOT*** *recommended during the* ***first*** *or* ***third*** *trimester without written consent from your OB/GYN.*

\****I confirm that I have not been diagnosed with any contraindications for colon hydrotherapy.***

**INITIAL HERE:\_\_\_\_\_\_\_\_\_\_\_\_** *(complete reverse side)*

Please **CIRCLE** any issues you are **CURRENTLY** experiencing:

Blood in Stool Painful/Difficult Bowel Movements Burning/Itching Anus Constipation/Diarrhea

Gas/Bloating Vomiting High Blood Pressure Hemorrhoids Bladder Infection Using Laxatives

If you are 45 years or older, when was your last colonoscopy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GI Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications/supplements you are currently taking and for what condition:

Medication/Supplement: Condition:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PLEASE READ and INITIAL:**

*I am aware that this clinic uses FDA Registered Medical Devices for Colon Hydrotherapy and only uses disposable sterile nozzles or speculums. Although all therapists on staff have certificates showing they have completed Device Training, they may not be required to be state licensed or have a degree in health care. This clinic does not have a licensed medical director on site. No studies have been conducted for this alternative and complimentary modality. I am aware that adverse events such as perforation, injury, or illness have been alleged and claimed with the use of colon hydrotherapy devices and/or home enema kits. Should I experience resistance during my insertion of the rectal nozzle, I will immediately stop my session. If during my session I experience discomfort or pain, I am responsible for immediately stopping my session.* **INITIALS:\_\_\_\_\_\_\_\_\_\_\_**

**I have reviewed and discussed with the Device Trained Therapist that I do not have any known contraindications or health concerns. I wish to proceed with my colon hydrotherapy session(s).**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_**

**As a trained Colon Hydrotherapist, I will always follow the FDA Device Manufacturer’s use and maintenance guidelines. I have reviewed and discussed this form with the above client.**

**Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**