

## CONFIDENTIAL HISTORY

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

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Alt. Phone: \_\_\_\_\_

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

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation: \_\_\_\_\_

How did you hear about us?

\_\_\_\_ Internet    \_\_\_\_ Personal Reference    \_\_\_\_ Other - Please Explain: \_\_\_\_\_

Why have you chosen to have a Colonic/Colon Hydrotherapy Session?

\_\_\_\_ Under a Medical Providers Care?    \_\_\_\_ By Prescription?    \_\_\_\_ 9th Amendment Right?

Medical Providers Name: \_\_\_\_\_

How many bowel movements per week? \_\_\_\_\_ In Pain? \_\_\_\_\_ Where? \_\_\_\_\_

Do you use laxatives? \_\_\_\_\_ What Kind? \_\_\_\_\_

Please list any medications or over-the-counter medications you are taking and for what ailment(s):

\_\_\_\_\_

Please list any surgical procedures along with the date performed and for what reason:

\_\_\_\_\_

Contraindications: Please check and date if the following apply to you:

\_\_\_\_ Abdominal Hernia

\_\_\_\_ Anemia

\_\_\_\_ Crohn's Disease

\_\_\_\_ Diverticulosis/Diverticulitis

\_\_\_\_ Intestinal Perforations

\_\_\_\_ Renal Insufficiencies

\_\_\_\_ Bladder Infections

\_\_\_\_ Itching Anus

\_\_\_\_ Hemorrhoids

\_\_\_\_ Abdominal Surgery

\_\_\_\_ Aneurysm-All Types

\_\_\_\_ Colitis

\_\_\_\_ Fissures & Fistulas

\_\_\_\_ Lupus

\_\_\_\_ Irritable Bowel Syndrome

\_\_\_\_ Bloating

\_\_\_\_ Constipation

\_\_\_\_ Colonoscopy

\_\_\_\_ Abnormal Distension

\_\_\_\_ Cancer of the Colon

\_\_\_\_ Hepatitis B or C

\_\_\_\_ Hemorrhaging

\_\_\_\_ Pregnant? Due Date \_\_\_\_\_

\_\_\_\_ AIDS

\_\_\_\_ Blood in Stool

\_\_\_\_ Rectal/Colon Surgery

\_\_\_\_ Rectal Bleeding

\_\_\_\_ Acute Liver Failure

\_\_\_\_ Infectious Disease

\_\_\_\_ Diarrhea

\_\_\_\_ Hemorrhoidectomy

\_\_\_\_ Congestive Heart Failure

\_\_\_\_ Cardiac Condition

\_\_\_\_ BM Difficult

Is there a history of colon cancer in your family \_\_\_\_ YES \_\_\_\_ NO

Any other considerations we should be aware of? \_\_\_\_\_

Have you experienced Colon Hydrotherapy before? \_\_\_\_ YES \_\_\_\_ NO Where? When \_\_\_\_\_

Do you participate in any other forms of alternative healing? \_\_\_\_\_

Do you exercise? \_\_\_\_\_ Are you on a special diet? \_\_\_\_\_

How frequently do you consume the following (per week): Red Meat \_\_\_\_\_ Poultry \_\_\_\_\_ Fish \_\_\_\_\_

Dairy \_\_\_\_\_ White Bread \_\_\_\_\_ Fruits \_\_\_\_\_ Vegetables \_\_\_\_\_ Soda/Pop \_\_\_\_\_ Natural Juicing \_\_\_\_\_

Grains \_\_\_\_\_ Alcohol \_\_\_\_\_ Coffee \_\_\_\_\_ Cigarettes \_\_\_\_\_ Fast Foods \_\_\_\_\_ Sugar \_\_\_\_\_

How many glasses of water do you drink daily? \_\_\_\_\_

### FULL DISCLOSURE

I UNDERSTAND AND FULLY DISCLOSE ANY AND ALL MEDICAL TREATMENTS THAT I HAVE HAD IN THE PAST ONE (5) YEARS THAT MAY DIRECTLY OR INDIRECTLY BE RELATED TO ME PARTICIPATING IN THE USE OF COLON HYDROTHERAPY. THIS MAY INCLUDE BUT IS NOT LIMITED TO GASTROINTESTINAL EVALUATIONS, DIAGNOSIS, PROCEDURES, MEDICATIONS, SURGERIES AND THE LIKE. ALSO, BUT NOT LIMITED TO ANY PROCTOLOGY DIAGNOSIS, EVALUATIONS, PROCEDURES, MEDICATIONS AND SURGERIES. BY SIGNING THIS FORM, I AM DISCLOSING THAT I HAVE NOT HAD ANY UNDISCLOSED GASTROINTESTINAL PROCEDURES SUCH AS; BUT NOT LIMITED TO EGD (ESOPHAGEAL STOMACH SCOPE), COLONOSCOPY, SIGMOIDOSCOPY, ANAL SCOPE AND THE LIKE. I HEREBY CONSENT TO THE SERVICES THAT WILL BE PROVIDED AS WELL AS MY OWN PHYSICAL LIMITATIONS AND I AGREE TO ASSUME THE RISK OF ACCEPTING THIS SERVICE. I ACKNOWLEDGE IF I HAVE ANY MEDICAL CONDITIONS THAT MAY BE AFFECTED BY THE SERVICE REQUESTED, I WILL ADVISE AND DISCUSS SUCH CONDITIONS WITH THE SERVICE PROVIDER. I AM AWARE THAT IT IS ALWAYS ADVISABLE TO CONSULT A PHYSICIAN BEFORE UNDERTAKING ANY SUCH SERVICE. I HAVE NOT BEEN DIAGNOSED WITH ANY CONTRAINDICATIONS FOR COLON HYDROTHERAPY. I AM AWARE THAT COLON HYDROTHERAPISTS ARE NOT PHYSICIANS AND THEREFORE DO NOT DIAGNOSE OR PRESCRIBE. I AM AWARE THAT ADVERSE EVENTS SUCH AS PERFORATION, INJURY AND ILLNESS HAVE BEEN ALLEGED AND CLAIMED WITH THE USE OF COLON HYDROTHERAPY AND ENEMA DEVICES. IF I EXPERIENCE RESISTANCE DURING THE INSERTION, I WILL IMMEDIATELY STOP MY SESSION. IF DURING THE SESSION I EXPERIENCE DISCOMFORT OR PAIN, I AM RESPONSIBLE FOR IMMEDIATELY STOPPING MY SESSION. I AM AWARE THIS FACILITY DOES NOT CLAIM TO CURE OR TREAT ANY CONDITION OR DISEASE.

**I FULLY UNDERSTAND AND ACCEPT ANY AND ALL LIABILITY IF THESE ARE NOT DISCLOSED IN WRITING AND PLACED IN MY FILE. I FURTHER RELEASE ALTERNATIVE HEALTH AND REHAB PLLC FROM ALL HARM REGARDING THESE ISSUES AS STATED ABOVE.**

Client

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(For clients 18 or under, the signature and attendance of the parent or guardian for insertion is required)

I have reviewed this form with my client

Therapist

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MAY WE CONTACT YOU VIA EMAIL OR VIA HOME ADDRESS WHEN OFFERS  
BECOME AVAILABLE? YES \_\_\_\_\_ NO \_\_\_\_\_**