



Patient Information - Colonic Hydrotherapy Therapy

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

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

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

How did you find us? \_\_\_\_\_

Are you currently under doctor's care? Yes/No If so, why? \_\_\_\_\_

Do you take any medication, if so which ones? \_\_\_\_\_

Do you have any immune disorders? HIV+ \_\_\_\_\_ AIDS \_\_\_\_\_ Other \_\_\_\_\_

Allergies: What type? \_\_\_\_\_

Cancer: What type? \_\_\_\_\_

Surgeries: Which one and when? \_\_\_\_\_

Last X-rays? \_\_\_\_\_

Last series of Chemotherapy? \_\_\_\_\_

List any other disorders requiring hospitalization or doctor's care? \_\_\_\_\_

Do you receive chiropractic care? Yes/No If so, how often? \_\_\_\_\_

Do you receive massage therapy? Yes/No If so, how often? \_\_\_\_\_

Have you ever had Vasovagal Syncope (Fainting Spells)? Yes/No

Have you ever had a colonic hydrotherapy? Yes/No If so, last series? \_\_\_\_\_ Results? \_\_\_\_\_

Have you ever had a Barium Enema? Yes/No If so, what year? \_\_\_\_\_

Have you ever had a Colonoscopy? Yes/No If so, what year? \_\_\_\_\_

Have you ever had a Colon Surgery? Yes/No If so, what year? \_\_\_\_\_

Have you ever had a Rectal Surgery? Yes/No If so, what year? \_\_\_\_\_

Please circle if you have any of the following: Anemia (severe), Aneurysm, Carcinoma, Cardiac Disease (severe, uncontrolled hypertension/high blood pressure), Crohn's Disease, Congestive heart failure, Diverticulitis (severe or acute), Fissures/fistulas, GI Hemorrhage/Perforation, Hemorrhoids (excessive bleeding present), Hernia (Incarcerated Abdominal), Prostatitis, Recent Abdominal Surgery (last six months), Tumors, Ulcerative Colitis.

If any are circled, colon hydrotherapy should be avoided, unless prescribed by a physician. If you do have any of these ailments, please provide a doctor's prescription to receive treatment today.

What does your daily diet consist of? Circle that apply

- |                                 |                               |                  |
|---------------------------------|-------------------------------|------------------|
| Meals with protein and starches | Fish                          | Coffee/Tea       |
| White flour products            | Milk                          | Bottled Water    |
| Fast Food/Restaurants           | Cheese                        | Alcoholic drinks |
| Packaged Foods                  | Sugar Free/Fat Free Products  | Antacids         |
| Red Meat                        | Multi-Grain Products          | Aspirin          |
| Late Night Snacks               | Fresh Fruits/Vegetables (Raw) | Vitamins         |
| Soft Drinks                     | Canned Fruits/ Vegetables     | Cigarette        |

**Bowel movements:**

- \_\_\_ One or more times per day
- \_\_\_ 2-3 times per week
- \_\_\_ Once per week
- \_\_\_ 2-3 times per month

Size: Small/Medium/Large  
 Color: Blk/Red/Green/White  
 Light Brown/Dark Brown  
 Shape: Pencil/Pebbles/Log  
 Thin/Flat

Do you need laxatives? Yes/No  
 Odor? Yes/No  
 Do you strain? Yes/No  
 Have rectal bleeding? Yes/No

Do you use fiber? Yes/No If so, what kind? \_\_\_\_\_  
 Do you exercise? Yes/No If so, how often? \_\_\_\_\_  
 What are your health goals? \_\_\_\_\_

In case of emergency, whom should we call? Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

I, the undersigned, hereby acknowledge that my therapist has not, is not and will not prescribe, (order for use as medicine) for me at any time and I, the undersigned, will not hold them accountable for such. The therapist is helping me with natural hygiene at my request and is not diagnosing, not treating disease, nor practicing any form of medicine. I confirm that I do not have the following contraindicated conditions which would make me ineligible for Colon hydrotherapy: Kidney Dialysis/Disease, Renal failure or renal insufficiency (kidney failure), Cirrhosis of the Liver, Pregnancy (first trimester). I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment. I hereby give consent for this colon hydrotherapy treatment and release the person performing the colon hydrotherapy procedure and the facility from liability associated with this and all subsequent treatments with the above understood.

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

OFFICE USE ONLY	Colonic Observations	Notes
Scope:	Adult Child	_____
Rectum:	Piles-Int. Piles-Ext Fissure	_____
Anus:	Normal Pubic Coccyx	_____
Bowel:	Atonic Spastic Ptosis	_____
Waste:	Const. Diarrhea Chyme Normal	_____
Mucus:	Normal New Toxic	_____
Cecum:	Normal Heavy Toxic	_____
Water:	5-Gal 10-Gal 15-Gal 20-Gal	_____
Perist:	Normal Hyper Hypo	_____
Gas:	Putrefaction Fermentation	_____