COLON HYDROTHERAPY

HEALTH HISTORY, INTAKE, INFORMED CONSENT AND RELEASE FORM

****Reminder: Please stop eating 2 hours prior and stop drinking 1 hour prior to your appointment****

NEW IN FLORIDA IN 2024: CS/CS/HB197 *states that we must collect the "…full legal name, home address and telephone number of the client or patient".* Thank you for helping us comply with State Law. □ ID Verified by LMT

Name: _____ Date: _____
Address: _____C/S/Z: _____
Phone # _____ Email address _____
Occupation _____ DOB (Month / Year) _____
Height _____ Weight _____
Emergency Contact _____ Phone # _____
How did you hear about us? Personal referral / Dr/Practitioner / Google / Natural Awakenings
Other: _____ If referral, who may we thank? _____

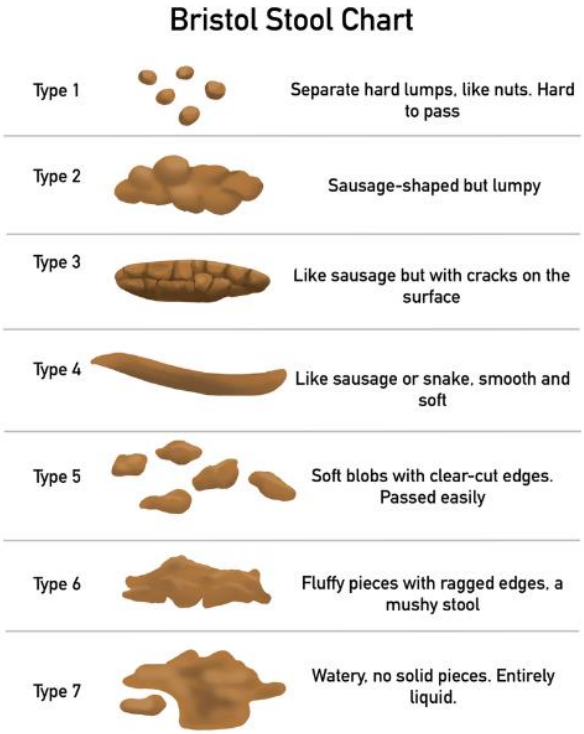
HEALTH HISTORY:
Are you currently under medical supervision? Circle: **Yes / No** If yes, briefly describe:
(Blood Sugar or Thyroid issues, High Blood Pressure or Cholesterol issues, etc.)
_____
_____

Doctor's Name _____ Type of Doctor: _____
Is Colon Hydrotherapy part of a protocol that a doctor or other healthcare professional has referred or prescribed for you? **Yes / No** Do you have a prescription for this visit? **Yes / No** If yes, do we have a copy on file? **Yes / No**
If yes, Date _____

Digestion: How would you describe your digestion? *Circle all that apply.*
Great! / Adequate / Poor / Acid Reflux / Bloating / Burning / Pain in Stomach / Indigestion / Ulcers
Do you have hemorrhoids, rectal problems (itching, burning, fissures, bleeding, etc.) or other complaints?
If yes, describe: _____
If you have seen a doctor about them, please describe the instructions, solutions, or treatments they have recommended: _____

Bowel Habits: How often do you have a bowel movement? 3 per day / 2 per day / 1 per day / _____
Typically, when do you move your bowels? Only after eating / Morning / Afternoon / Evening / Varies
How are your bowel eliminations normally? Complete / Requires Straining / Effortless / Urgent / Varies
Have you moved your bowels today? **Yes / No**

Consistency: Please use the Bristol Stool Chart to identify and circle the type(s) of stools you produce.



Other:
brown / black / whitish / greenish / lots of mucus /lots of gas / foul smell
Is the gas related to certain food (s)? **Yes / No**
If yes, describe: _____
Do you use a stool softener or laxative? **Yes / No**
Herbal laxative? **Yes / No** Suppository? **Yes / No**
If yes, how often? _____
How long (days, months, years)? _____
Product name (s): _____
Do you have parasites? **Yes / No**
If yes, how do you know? _____

Colonic History: Have you ever had a Colonic before? **Yes / No** If yes, when? _____
Where? _____
What did you like / dislike about your experience? _____
Type of colonic system used C*ircle all that apply.* Closed / Open / Gravity / Not Sure
Other forms of cleansing you are using or have used: _____

What are your goals for this colon hydrotherapy appointment? _____
For future sessions? _____

Other health concerns, if any: List top: _____
_____

Abdominal area surgeries: *Circle & list dates.* C-Section / Gallbladder / Gastric Bypass / Hysterectomy
Lap Band / Vaginal Mesh / Appendectomy Other _____
If yes to any of the above, do you feel that your bowel habits changed afterwards? **Yes / No** If yes, describe:
_____
Do you have any problems/pain in the lower back (lumbar region)? **Yes / No**

For Women: Date of last menstrual cycle: _____ Are you pregnant? **Yes / No**
Have you given birth? **Yes / No** If yes, when and how many deliveries? _____

Medications & Supplements: List all you now take regularly including over the counter. ***Please be thorough in this section*** as certain medications or combinations of medications can be contraindicated for colon hydrotherapy.

Medication/Condition	**Medication/Condition**
/	/
/	/
/	/
/	/
/	/

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

GENERAL HEALTH AND HABITS:

Energy: On a scale from 1 to 10 where 1= "can't get out of bed" and 10= "optimal energy"
Please rate your normal energy level: _____ Any relation to food or drinks? _____
If yes, describe examples: _____

Diet: What type of diet best describes your **general dietary habits?** *(Circle the best response)*

Junk food/fast food eater Combination (from junk food to health conscious) Vegetarian
Vegan raw macrobiotic Natural food eater (over 50% organic) Health conscious

How many servings of fruits/veggies do you eat per day? F: _____/Day V: _____/Day
How much dairy do you eat per day? _____ How much meat do you eat per day? _____
Water: How much water do your drink per day? _____ glasses or _____ ounces
Water Source: Tap (from city or well) / Bottled / Filtered / Boiled / Whatever is available

Smoking: Do you currently smoke? **Yes / No** If yes, how much? _____ How long? _____
Alcohol: Do you drink alcohol? **Yes / No** If yes, how much? _____ How long? _____
Stress: On a scale from 1 to 10 where 1 = "is mellow" and 10 = "Stressed Out"
Please rate your current stress level: _____ what are the main source of your stress? _____
_____
If you're stress, level 5 or more, what step(s) are you taking to reduce your stress? _____
_____
Do you notice changes in your bowel habits when you make any changes to exercise, diet, water intake, and
Stress? **Yes / No** If yes, please explain: _____

*** * * 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, in which case, a physician prescription is required before treatments will be provided at our facility.

If you have any of the conditions listed in the left column, colon hydrotherapy is NOT advised. Once they have subsided or been eliminated, colon therapy may be indicated, and you can feel free to book your appointment at that time. The conditions listed in the right column should accompany a physician's prescription before being treated in our office.

Y/N	ABSOLUTE CONTRAINDICATIONS	Rx?	RELATIVE CONTRAINDICATIONS, Rx Required
	Abdominal Distention		Abdominal Surgery, within 12 weeks
	Abdominal Hernia		Anemia, severe
	Acute Liver Failure		Aneurysm, all types
	Anal Fissure / Fistula		Cardiac disease, Hypertension, uncontrolled
	Cirrhosis		Carcinoma
	Colostomy		Crohn's Disease, acute inflammatory stage
	Congestive Heart Failure (CHF)		Colon Cancer
	Epilepsy or History of Seizures		Colon Surgery, < 6 months post-op
	Heart attack, within 6 months		Diverticulitis, inflammation, or infection of diverticulum
	Intestinal Perforation		Hemorrhaging, especially in digestive tract
	Kidney dialysis/disease, renal failure, or insufficiency		Hernia, inguinal or abdominal
	Miscarriage or Abortion, within 6 months		Hemorrhoids, severe or bleeding
	Pregnancy, until 6 weeks post-partum		Prostatitis
	Rectal Bleeding		Tumor in rectum or large intestine
	Under the age of 18		Ulcerative Colitis

NOTES:

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

_____ Date: _____

Client Name (Signature)

_____

Client Name (Printed clearly)

INFORMED CONSENT AND RELEASE, FINANCIAL & CANCELLATION POLICY:

Neither Professional Lymphatic Therapy and Colonics nor its associates do the following things, either implied or intended:

- We do not diagnose
- We make no attempt to cure or treat any condition
- We make no claims to imply or any claims to cure or treat any condition
- We do not claim that any supplemental material we may discuss will cure any condition, or that its purpose is to treat any condition
- We do not prescribe or treat disease, However, we do attempt to educate you on nutrition, diet and exercise but we always defer to the recommendations of your primary health care provider, physician or practitioner

I have been made aware of all contraindications for colon hydrotherapy and am here today and in the future by my choice and solely on my own behalf. I hereby release and discharge Professional Lymphatic Therapy and Colonics, LLC and its agents, employees, related and affiliate entities from any and all claims which I or my agents ever had, now have or may have relating to or arising out of services provided or recommendation that I have received. I acknowledge that it is my responsibility to consult with my physician or other health care providers relating to any disease or condition that I may have.

♦ Cancellations should be communicated to the therapist at least 24 hours in advance of scheduled appointment to avoid paying a full fee for the missed session. ♦ Payment is due at the time services are rendered, however, late arrival (less than 10 minutes) will result in a shortened session; full fee remains due. Late arrival (more than 10 minutes) compromises our ability to run on time, hence, your session will be cancelled, and a full fee remains due. ♦ Any fees we incur as a result of a charge-back, bounced check, declined card, etc., will be passed on to the client and expected to be paid back to us in full within 10 days of service rendered. ♦ Any type of sexual misconduct or indication of being impaired by alcohol or drugs will be grounds for immediate termination of the session and all fees remain due. ♦ It is the Client's Responsibility to keep therapist informed of changes in health status, medications and any known contraindications. ♦Draping Policy: We require full draping at this facility.

I have read the informed consent, cancellation and payment policies and I understand them and am signing this release voluntarily. I am not a minor (under the age of 18).

_____ Date: _____

Client Name (Signature)

_____

Client Name (Print clearly Please)