Complete the following for Colon Hydrotherapy

Why have you chosen to have a colonic session?

Doctor suggestion or prescription:☐ Right to Self Treat:☐ Other: _____

If you have been diagnosed with any the following, a referral from your doctor is required before receiving colon hydrotherapy:

- ☐ Abdominal Hernia
- ☐ Dialysis
- ☐ Abdominal Surgery
- ☐ Diverticulosis/Diverticulitis
- ☐ Abdominal Distention
- ☐ Rectal Fissures & Fistulas
- ☐ Acute Liver Failure
- ☐ Hemorrhaging
- ☐ Anemia
- ☐ Hemorrhoidectomy
- ☐ Aneurysm- All Types
- ☐ Intestinal Perforations
- ☐ Carcinoma of the Colon
- ☐ Lupus
- ☐ Crohn's Disease
- ☐ Rectal/ Colon Surgery
- ☐ Renal Insufficiencies
- ☐ Colitis
- ☐ Jaundice
- ☐ Heart Trouble
- ☐ Rectal Bleeding
- ☐ Currently Pregnant/Date of last menstrual cycle? _____

☐ Are you currently taking any medications which may weaken the intestinal wall?

Do you now have or have you recently (within the last year) experienced any of the following:

- ☐ Painful Bowel Movement
- ☐ Bladder Infection
- ☐ Blood in Stool
- ☐ Burning/ Itching Anus
- ☐ High Blood pressure
- ☐ Hemorrhoids
- ☐ Barium Enema
- ☐ Colonoscopy
- ☐ Vomiting

General Health Information:

Please indicate any of the following which you have currently or recently experienced. Rate severity of any indicated conditions on a scale of 1 to 10, with 10 being the most severe.

- ☐ Acne
- ☐ Allergies
- ☐ Belching/Gas
- ☐ Boils
- ☐ Chronic Cough
- ☐ Difficult Breathing
- ☐ Difficult Digestion
- ☐ Dry Skin
- ☐ Joint Pain
- ☐ Itching
- ☐ Rashes
- ☐ Sweating
- ☐ Fever
- ☐ Chills
- ☐ Nausea
- ☐ Fainting
- ☐ Nervousness
- ☐ Poor Appetite
- ☐ Excessive Hunger
- ☐ Bruises Easily
- ☐ Chest Pain
- ☐ Pain in Abdomen
- ☐ Constipation
- ☐ Overweight
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Kidney Problems
- ☐ Liver Trouble
- ☐ Gall Bladder Trouble
- ☐ Parasites
- ☐ Headaches
- ☐ Depression
- ☐ Insomnia
- ☐ Fatigue
- ☐ Diarrhea

☐ **Have you ever been diagnosed with an infectious disease?** (HIV/AIDS, Hepatitis A, B, or C, etc.)

Explain: _____

Are you currently taking laxatives? **Yes**☐ **No**☐ **How often? _____**(times per week)

Have you had professional colon hydrotherapy recently (within the last year)? Yes☐ **No**☐

If so, where and when? _____

What is your primary health goal or concern at this time? _____

_____

Colon Hydrotherapy Acknowledgement

I have discussed all indicated contraindications on this form, if any, with the therapist as it relates to the use of colon hydrotherapy. I am aware that Colon Hydrotherapists are not physicians and cannot diagnose, treat, prescribe or perform any invasive procedures including rectal tube insertion. I am aware that possible adverse events such as bowel perforation, bowel injury and illness have been alleged and claimed as a result use of colon irrigation and enema devices. As such, I am responsible for my own rectal tube self-insertion. If during a session I experience any discomfort or pain, I am responsible for immediately stopping the session and notifying the therapist. I acknowledge ACM makes no claim for Colon Hydrotherapy as a cure or treatment for any medical condition or disease. I understand Colon Hydrotherapy is not a substitute for medical treatment.

Informed Consent

I, the undersigned, agree that Colon Hydrotherapy and/or colon irrigation is not a proven method, cure, or treatment of any disease, condition or illness, nor has it been portrayed to me as such. Colon irrigation, as used in this facility is a self-administered procedure where I, as the user of the device, am solely responsible for my own actions and release all others of any and all liability.

The colonic device utilized in this facility is a FDA Registered Class II gravity device. I understand I will insert my own rectal tube and will be in full control of the procedure at all times. The facility I have chosen to visit operates under existing state & federal laws at the time I sign this waiver of consent and that that those laws may change. Neither I, nor my family, nor my representative(s) will hold the equipment manufacturer, facility or their employees responsible for my personal choice to receive colon irrigation therapy, nor hold them liable for any changes or variations of the law after my dated signature below. All results of my session(s) are contributive to research and utilization in future programs of Self Health Aid, while preserving my privacy.

If you are currently taking any medication for any condition, either prescription or non-prescription or if you have ever been diagnosed with any intestinal condition or have taken any medication that can weaken the intestinal walls you should consult a physician before using colonic irrigation. If you are not sure of the side effects of any drugs you are using, you should consult a licensed health care provider.

By my signature below, I attest that all contraindications/adverse conditions have been fully explained and discussed with me. I certify that none of contraindications/adverse conditions applies to me. I certify and affirm that I have listed all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I fail to do so.

Atlanta Colonic and Massage does not claim to treat or cure any condition, illness or disease.

Cancellations and Rescheduling:

We at Atlanta Colonic & Massage understand that sometimes a client may need to cancel or reschedule an appointment. We do require a minimum of a 24-hour notice for cancellations or rescheduling of appointments, to ensure therapist and facilities availability, for other clients. **No call/No shows will be charged l00% of total services scheduled for that day.**

I have read and understand Atlanta Colonic & Massage's cancellation/rescheduling policy.

Client Printed Name: _____

Last *First* *MI*

Client Signature: _____ _____

(for clients under age of 18, signature of parent/legal guardian required) *Date*