

Complete for Colon Hydrotherapy

Why have you chosen to have a colonic session?

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

Have you experienced professional colon hydrotherapy (within the last 5 years)? Yes No

If so, where and when? _____

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

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

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Painful Bowel Movement | <input type="checkbox"/> Burning/ Itching Anus | <input type="checkbox"/> Barium Enema |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Colonoscopy |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> 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.

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

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)

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

Colon Hydrotherapy

Acknowledgement & Informed Consent

I, the undersigned, confirm I have discussed all contraindications on this form as they may apply to me with the therapist, related to the use of Colon Hydrotherapy also known as Colon Irrigation or Colonics. I acknowledge Atlanta Colonic & Massage (ACM) personnel, including 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 type 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, the undersigned, agree that Colon Hydrotherapy is not a proven method, cure, or treatment of any medical condition, disease or illness, nor has it been portrayed to me as such by ACM. I fully understand Colon Hydrotherapy is not a substitute for any medical treatment. Atlanta Colonic and Massage does not claim to treat or cure any condition, illness or disease.

The Colon Hydrotherapy equipment 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 Hydrotherapy, nor hold them liable for any changes or variations of the law after my dated signature below.

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 colon irrigation and enema type devices. If you are unsure 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.

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

Client Printed Name: _____
Last First MI

Client Signature: _____
(for clients under age of 18, signature of parent/legal guardian required) Date