Health History Questionnaire for Colon Hydrotherapy

Please PRINT and Answer all Questions: Date: ____/____/____

NAME:________________________ (cell ph) __________ (work ph) __________

ADDRESS:____________________ City______________ State ______ Zip______

OCCUPATION:______________________________________ How Long? ______

HEIGHT: ________ WEIGHT: ________ BIRTH DATE: ______________ AGE:______

Are you Under a Physicians Care? _____ Name__________________ Type:______

(ICE) In Case of Emergency contact:______________ Relation: ________ Phone: ______________

What is a contraindication?** (con·tra·in·di·ca·tion)* ***A contraindication is a specific health condition in which A drug, procedure, treatment or surgery is inadvisable, as it may be harmful to the health of the patient.

* Contraindications: [√] and Date if ever had any of the Following:

DATE		DATE	
_____	**Abdominal Hernia**	_____	**Dialysis Patient**
_____	**Abdominal Surgery**	_____	Diverticulosis/**Diverticulitis**
_____	**Abnormal Distension**	_____	**Fissures & Fistulas**
_____	**Acute Liver Failure**	_____	**Hemorrhaging**
_____	**Anemia**	_____	**Hemorrhoidectomy**
_____	**Aneurysm - All Types**	_____	**Intestinal Perforations**
_____	**Cancer-Type**__________	_____	**Lupus**
_____	**Cardiac Condition**	_____	**Pregnant** -(due date ______)
_____	**Crohns Disease**	_____	**Rectal / Colon Surgery**
_____	**Colitis**	_____	**Renal Insufficiencies**

Please check [√]

_____ Hemorrhoids
Internal_____ External_____
_____ Rectal or Blood in Stool
_____ Recent Colonoscopy
_____ Use Laxatives
_____ BM Painful / Difficult
_____ Burning / Itching Anus
_____ Constipation/Diarrhea
_____ Vomiting _____ Bloating
_____ High Blood Pressure
_____ Infectious Disease
_____ Date of Last Menstrual
_____ Allergic to Latex
_____ Bladder Infection
Other__________________
or use back of form.

Please [√] Date IF you have any above contraindications*.

I have NOT been diagnosed with any contraindications for colon hydrotherapy: Client Initials X________

READ and INITIAL: I am aware that this Center uses FDA Colon Hydrotherapy Device(s) and the Trained Therapist is not required to be State Licensed. This Center does have a Licensed Medical Director that may NOT be on site. No Studies have been conducted for this alternative and complementary modality. I am aware adverse events such as perforation, injury and illness have been alleged and claimed with the use of colon hydrotherapy devices and/or Enema kits. Should I experience resistance during my nozzle insertion, I will immediately stop my Session.
If during the session, I experience discomfort or pain, I am responsible for immediately stopping my session.
As a Trained Therapist, I do NOT insert, diagnose, prescribe and do not cure or treat any condition or disease.
I have read and understand my responsibilities for colon hydrotherapy sessions: Client Initials X________

I have reviewed and discussed with the Device Trained Therapist, that I do not have any known Contraindications or any Health Concerns and I wish to proceed with my colon hydrotherapy session(s):

CLIENT SIGNATURE: X______________________________ Date ____/____/____

(For Clients 18 or under, the signature & attendance of the parent or guardian for insertion is required.)

As a Trained Therapist, I will always follow the LIBBE Manufacture operation & maintenance guidelines.
I have reviewed and discussed this form with above client. **Therapist Signature: X**__________________

How did you hear about us?

• Physician: ___________ • Friend____ • Paper____

• Family Member____ • Coupon where:____________

• Internet__________ • Colonic.Net ____ • Sign____

• Other?______________________________

Client First Session Evaluation: Yes / No

Did Therapist review Contraindications and inquire to any health issues? _____

Were Device, Room, Restrooms Clean? _____

Were you Covered and Comfortable? _____

Were your results Satisfactory? _____

Will you recommend to family/friends? _____

Problems or Discomfort during session? _____
Please Explain: ____________________

How do you feel?____________________

____

Client Signature:

X____________________________

Pre Paid Sessions INITIALS

#	Date	Therapist	Client
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Therapist Notes of Clients needs:

Flex cut ___ normal or needs _____ Inches

Prefers ______________ style Nozzle

Likes ________________ session room.

Tummy Warmer ____ Yes ____ No

Other:-____________________________

PREPAID DISCOUNTED COLONIC SESSION PACKAGES SOLD AS FOLLOWS:

1. All Prepaid Discounted Colonic Sessions are to be used within six (6) months of purchase.
2. No Show appointments are counted as a used session without a 12 hour advance cancellation.
3. Health History should be updated after twelve sessions. No Refunds! Non-Transferable!

CLIENT SIGNATURE: X____________________________ Date ___/___/___

Possible Side Effects: Increased Energy, Nausea, Vomiting, Cramping, Light Headed, Excessive Gas or Bloating, Overheating, Diarrhea, Headaches, Temporary Increase in Body Odor, Joint or Body Aches, Increased Appetite, Hemorrhoids: *(which may be irritated, inflamed or bleed)*,

Precautions: Over Hydration: (may occur *when multiple colonic sessions are done during a short period of time)* Perforation of Rectum / Colon, Irritation / Inflammation / Allergic Reactions of the rectum due to lubricant, Water Over temperature, Other Issues when colonic equipment is improperly used, failure to use approved disinfectants or perform the monthly and annual maintainance to prevent bacteria growth and/or operated by untrained therapists.