

## 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
<input type="checkbox"/> Abdominal Hernia	<input type="checkbox"/> Dialysis Patient
<input type="checkbox"/> Abdominal Surgery	<input type="checkbox"/> Diverticulosis/Diverticulitis
<input type="checkbox"/> Abnormal Distension	<input type="checkbox"/> Fissures & Fistulas
<input type="checkbox"/> Acute Liver Failure	<input type="checkbox"/> Hemorrhaging
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hemorrhoidectomy
<input type="checkbox"/> Aneurysm - All Types	<input type="checkbox"/> Intestinal Perforations
<input type="checkbox"/> Cancer-Type _____	<input type="checkbox"/> Lupus
<input type="checkbox"/> Cardiac Condition	<input type="checkbox"/> Pregnant -(due date _____)
<input type="checkbox"/> Crohns Disease	<input type="checkbox"/> Rectal / Colon Surgery
<input type="checkbox"/> Colitis	<input type="checkbox"/> 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 maintenance to prevent bacteria growth and/or operated by untrained therapists.