



bcollingwood@nycap.rr.com

PLEASE PRINT AND ANSWER ALL QUESTIONS

Date: ____ / ____ / 2019

Name _____ Home Phone _____
 E-Mail _____ Cell Phone _____
 Address _____ City _____ State ____ Zip ____
 Height _____ Weight _____ Birth Date ____ / ____ / ____ Age _____
 Occupation _____ How Long? _____ Referred By: _____

ARE YOU UNDER A MEDICAL PROVIDER'S CARE? _____ Provider's Name _____ Prescriptions? _____

Are you in any pain? _____ Where? _____

How often do you have bowel movements? _____ Difficult or Straining? Yes / No / Sometimes

WHY HAVE YOU CHOSEN TO HAVE COLON IRRIGATION(S)? _____

PLEASE CHECK (✓) ALL THAT APPLY: Right to self-treat _____ Good Health _____ Lose Weight _____

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Burning/itching anus | <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Infectious disease |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Constipation | <input type="checkbox"/> Use of Laxatives | <input type="checkbox"/> Recent Barium Enema |
| <input type="checkbox"/> BM painful | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Recent Colonoscopy |
| <input type="checkbox"/> BM difficult | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Bladder Infection | Other: _____ |

CONTRAINDICATIONS: Please DATE if you have ever had any of the following:

| | | |
|--|---|---|
| <input type="checkbox"/> ____/____/____ Abdominal Hernia | <input type="checkbox"/> ____/____/____ Colitis | <input type="checkbox"/> ____/____/____ Colon/Rectal Surgery |
| <input type="checkbox"/> ____/____/____ Abdominal Surgery | <input type="checkbox"/> ____/____/____ Dialysis | <input type="checkbox"/> ____/____/____ Renal insufficiency |
| <input type="checkbox"/> ____/____/____ Abnormal Distention | <input type="checkbox"/> ____/____/____ Diverticulosis/Diverticulitis | <input type="checkbox"/> ____/____/____ Hypertension |
| <input type="checkbox"/> ____/____/____ Acute Liver Failure | <input type="checkbox"/> ____/____/____ Hemorrhaging | <input type="checkbox"/> ____/____/____ Fissures/Fistulas |
| <input type="checkbox"/> ____/____/____ Anemia | <input type="checkbox"/> ____/____/____ Hemorrhoidectomy | Currently on medications that may weaken intestinal walls: _____ _____ _____ |
| <input type="checkbox"/> ____/____/____ Aneurysm - all types | <input type="checkbox"/> ____/____/____ Intestinal Perforations | |
| <input type="checkbox"/> ____/____/____ Carcinoma of Colon | <input type="checkbox"/> ____/____/____ Lupus | |
| <input type="checkbox"/> ____/____/____ Crohn's Disease | <input type="checkbox"/> ____/____/____ Pregnant (due date) | |

I have not been diagnosed with any contraindications for colon irrigation, *see above*. I am aware that colon irrigation and enema device facilities are not physicians and therefore do not insert, diagnose or prescribe. I am also aware adverse events such as perforation, injury and illness have been alleged and claimed with the use of colon irrigation and enema devices. I am responsible for my own insertion in privacy; if I experience resistance during my insertion, I will immediately stop my session. If during the session I experience pain, I am responsible for immediately stopping my session. By signing, I acknowledge this facility does not claim to cure or treat any condition or disease. **IF ANY CONTRAINDICATIONS ARE NOTED, PROVIDE A WRITTEN PRESCRIPTION FROM A PHYSICIAN FOR COLON HYDROTHERAPY ON AN AS NEEDED BASIS.**

CLIENT SIGNATURE _____ DATE ____ / ____ / 2019

- For clients 18 or younger, signature & attendance of the parent or guardian is required for insertion *

I have reviewed this form with my client. COLON HYDROTHERAPIST SIGNATURE _____