Colonic History Form

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**Health History should be updated after twenty-three sessions within a year.*

Please PRINT and Answer all Questions: **Date:** ____/_____/20____

NAME:_____ Cell _____ Home_____ Work_____

ADDRESS:_____ **City**_____ **State**____ **Zip**_____

EMAIL:_____

OCCUPATION:_____ **EMERGENCY CONTACT NAME:**_____ **PHONE:**_____

GENDER:_____ WEIGHT:_____ BIRTH DATE: _____ AGE: _____

Why have you chosen to have Colon Irrigation Session(s)?
•Reason_____

•Under a Medical Provider's Care? ____ Reason? _____ Medical Provider Name_____
Are you In Pain _____ Where?_____

• **Contraindication's:** ***(√)*** and **Date if ever had any of the following:**

DATE		DATE	
_____	**Abdominal Hernia**	_____	**Diverticulosis/Diverticulitis**
_____	**Abdominal Surgery**	_____	**Fissures & Fistulas**
_____	**Abnormal Distension**	_____	**Hemorrhaging**
_____	**Acute Liver Failure**	_____	**Hemorrhoidectomy**
_____	**Anemia**	_____	**Intestinal Perforations**
_____	**Aneurysm - All Types**	_____	**Lupus**
_____	**Carcinoma of the Colon**	_____	**Pregnant** *due date*:_____
_____	**Cardiac Condition/ Stroke**	_____	**Rectal / Colon Surgery**
_____	**Crohns Disease**	_____	**Renal Insufficiencies**
_____	**Colitis**	_____	**Dialysis Patients/Cancer**

If Any Checked - Explain:_____

_____Allergies
_____Bladder Infection
_____Bloating
_____Blood in Stool
_____BM Painful /Difficult
_____Burning / Itching
_____Anus Constipation
_____Diarrhea
_____Infectious Disease
_____Hemorrhoids
Internal___External____
_____Rectal Bleeding
_____Recent Barium Enema
_____Recent
_____Colonoscopy Strain
_____Use Laxatives
_____Vomiting
_____Date of Last Menstrual
Other_____

I have not been diagnosed with any contraindications for colon irrigation. (See above*.)
I am aware that this colon irrigation and enema device facility has a Licensed Medical Director that is not on site.
I am aware adverse events such as perforation; injury and illness have been alleged and claimed with the use of Colon Irrigation and enema devices. Should I experience resistance during the 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. I am aware that Certified Therapists do not insert, diagnose, prescribe and do not cure or treat any condition or disease.
(See Back of form for more complete list of possible side effects.)

CLIENT SIGNATURE: **X**_____Date ___/___/
(For Clients 18 or under, the signature & attendance of the parent or guardian for insertion is required.)

I have reviewed this form with my client. **Therapist Signature**: **X**_____

Physician Signature: **X**_____Date ____/____/ Prescription Exp:_____

List all Medication & purpose:_____

Most recent medical service/hospitalization? (Date & Reason) _____

Pertinent Past Medical History_____

Have you ever had a colonic? _____Where? _____Date?_____

Do you exercise regularly? _____

When was your last bowel movement?_____

Recognizing that side effects and risk factors are very uncommon, but can occur; consequently, in rare instances, such effects and factors, included but not limited to: temporary bloating, gas, distension, fatigue, nausea, flu like symptoms, hemorrhoids or piles, enlarged, hardened or painful testacies, and/or tear of the anus, rectum, colon, sphincter, can occur and require immediate medical treatment. Diarrhea, Headaches, Flu like symptoms, Perforation of Rectum/Colon (seek medical attention), Hemorrhoids: (which may be irritated, inflamed or bleed), Decreased electrolytes: (when multiple colonic sessions are done during short period of time) Irritation / Inflammation / Allergic Reactions of the rectum due to lubricant

I_____, acknowledge that I have been diagnosed with and or being treated for _____by a medical doctor. I further acknowledge that I am seeking out Colon Hydrotherapy to be performed by an I-ACT Certified, knowledgeable, trained professional, Colon Hydrotherapist. However, I do understand and agree that the service I am seeking in no way claims or is expected to have any effect, positive or negative, on treatment I am receiving for _____.

As such, I hereby agree and assume the risk in full for any and all of the aforementioned side effects and risk factors; for any and all services received at this clinic; and for my voluntary participation, with full knowledge of the risks inherent in such procedure. Wherein, I further agree to hold harmless: Ms. Margie Ford, The Medical Director, prescribing Physicians, Utopian Health and Wellness, Inc., its agents, directors, employees, and anyone involved in any level of organizing or aiding in the arrangements of such procedure, from any and all claims and/or liabilities, whether direct or indirect, for any and all side effects and risk factors arising from my procedure and/or participation; and agree to assume the full risk and responsibility for any foreseen and/or unforeseen results from said voluntary procedure and participation whatsoever.

24 hour advance cancellation notice required (without charge).

CLIENT SIGNATURE: X_____Date ___/___/___

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