

# 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

\_\_\_\_\_ Abdominal Hernia

\_\_\_\_\_ Abdominal Surgery

\_\_\_\_\_ Abnormal Distension

\_\_\_\_\_ Acute Liver Failure

\_\_\_\_\_ Anemia

\_\_\_\_\_ Aneurysm - All Types

\_\_\_\_\_ Carcinoma of the Colon

\_\_\_\_\_ Cardiac Condition/ Stroke

\_\_\_\_\_ Crohns Disease

\_\_\_\_\_ Colitis

DATE

\_\_\_\_\_ Diverticulosis/Diverticulitis

\_\_\_\_\_ Fissures & Fistulas

\_\_\_\_\_ Hemorrhaging

\_\_\_\_\_ Hemorrhoidectomy

\_\_\_\_\_ Intestinal Perforations

\_\_\_\_\_ Lupus

\_\_\_\_\_ Pregnant *due date:* \_\_\_\_\_

\_\_\_\_\_ Rectal / Colon Surgery

\_\_\_\_\_ Renal Insufficiencis

\_\_\_\_\_ Dialysis Patients/Cancer

\_\_\_\_\_ 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 \_\_\_\_\_

If Any Checked - Explain: \_\_\_\_\_

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.)*