1145 Bethel Rd
Port Orchard, WA 98366
(360) 876-5000

HEALTH HISTORY QUESTIONNAIRE FOR COLON HYDROTHERAPY

Please PRINT and Answer all Questions on Both Sides Date: ___/____/____

NAME: ________________________________ PHONE: ______________ ALT PHONE: ______________

ADDRESS: ________________________________ CITY:_________________ STATE:____ ZIP:__________

EMAIL ADDRESS: ____

OCCUPATION: ____ HOW LONG:_________________

HEIGHT: _________ WEIGHT: __________ BIRTH DATE: _________________________ AGE: ___________

Are you under a physician's care: ______ NAME OF PHYSICIAN: _______________________ TYPE: _______

EMERGENCY CONTACT: __________________________ RELATION: _____________ PHONE: ___________

***CONTRAINDICATIONS: PRINT THE DATE OF OCCURRENCE IF YOU'VE EVER HAD THE FOLLOWING:**

_____ Abdominal hernia
_____ Acute liver failure
_____ Cancer (type _________)
_____ Colitis
_____ Fissures & Fistulas
_____ Lupus
_____ Renal insufficiencies
_____ Abdominal surgery
_____ Anemia
_____Cardiac Condition
_____ Dialysis
_____ Hemorrhaging
_____ Pregnant (due date _____)
_____ Abnormal distension
_____ Aneurysm – All types
_____ Crohn's Disease
_____ Diverticulosis/Diverticulitis
_____ Intestinal Perforations
_____ Rectal/Colon surgery

***OR I have NOT been diagnosed with any of the above contraindications: Initial X_____**

Please check if you've had any of the following:

_____Rectal bleeding or blood in stool
_____BM painful or difficult
_____ Vomiting
_____ Infectious disease
_____ Hemorrhoids (_____ internal/_____ external)
_____ Recent colonoscopy
_____ Burning/itching of anus
_____ Bloating
_____ Allergic to latex
_____Use laxatives
_____Constipation/Diarrhea
_____ High blood pressure
__/___Last menstrual period

READ AND INITIAL: I am aware that this center uses a FDA Colon Hydrotherapy System and the Trained Therapist is not required to be state licensed. This Center does have a Licensed Medical Director that may or 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.
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 initials X_____

Possible side effects: Increased energy, nausea, vomiting, cramping, light headedness, 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.
Client initials X_____

CANCELLATIONS: There is a 24-hour cancellation policy. I understand that if an appointment is missed or cancelled "for any reason" with less than 24-hour notice, I will be billed a no-show fee of $40. If I need to cancel or reschedule an appointment, I will notify the clinic as soon as possible. If there is a 24-hour notice I will not be charged. The clinic's voicemail may be reached 24 hours a day and the date and time of phone calls are recorded. Client initials X_____

A pattern of more than two missed appointments or cancellations per year may be cause for revocation of my standing appointment requiring that I make future appointments on a week to week basis depending on the availability of current appointment times. Client initials X_____

Client signature: X____ Date: _____/_____/_____

As a trained therapist, I will always follow the LIBBE Manufacture operation & maintenance guidelines. As a trained therapist, I do NOT insert, diagnose, prescribe, and do not cure or treat any condition or disease.
I have reviewed and discussed this form with the above client. Therapist signature: ___________________________