

COLON HYDROTHERAPY

200 North Mill Street

Lewisville, Texas 75057

(All Clients Information is Kept Strictly Confidential)

Name: _____ Birth Date: _____ Age: _____

Address: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Referred by: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Physician: _____

Have you ever had Colon therapy before? _____ If yes, when was your last
colonic? _____

What is the purpose for this visit? _____

Bowel Movement Today: Yes ___ No ___ How many Bowel Movements per day? _____

Use Laxatives, if so what kind and how often: _____

Other Prescriptions or Natural Herbs?

Colonoscopy (if so when?) _____

Colon Hydrotherapy has not been presented to me as a treatment or cure for any illness or specific disease, or with any guarantees to benefit or heal a disease. Whether or not I participate in a Colon Hydrotherapy session is my decision, which I have chosen as a positive action for my personal preventative health care. Colonic is not a medical treatment. I understand that the therapist providing colon hydrotherapy is not physician and that they do not treat, cure, prescribe or diagnose.

Abdominal Surgeries within the last 3 years?

Are you pregnant? Yes _____ No _____

Below is a list of health conditions. Please check any that apply to you:

Diabetes	Skin rashes	Arthritis
Kidney Issues	Headaches	Migraines
Gall Bladder or Appendix Removed	Fever	Allergy
Constipation	Seizures	Yeast/Fungal Infection
Diarrhea	Fatigue	Sleep Disturbance
Chronic Gas	Gas/Bloating	Nausea
Indigestion	Stomach Ulcer	Anemia
Acid Reflux	Stroke	Hypertension
Liver Issues	Hepatitis	Colitis
Heart Problems	Dizziness	Parasites

Health Conditions not listed: _____

CONTRAINDICATIONS THAT WOULD PROHIBIT YOU FROM A COLONIC PROCEDURE:

Cancer of the Colon or GI Tract	Recent Colon or Rectal Surgery	Diverticulitis
Acute Abdominal Pain	Heart Attack	Hemorrhoids
Congestive Heart Failure	General Debilitation	Epilepsy/Psychoses
Uncontrolled Hypertension	Vascular Aneurism	Cirrhosis
Renal Insufficiency	Fissures/Fistula	Pregnancy
Carcinoma of the Rectum	Abdominal Surgery	Acute Crohn's
Disease		

Your Health Goal or Concern is? _____

Anything about you that I should know? _____

Please sign below stating that the information on this form is accurate and complete.

All information is held strictly confidential. Thank you for helping us help you!

Signature of Client

Date Signed