

***Cleanse Thyself Purely***

670 W Arapaho Rd, #10A  
Richardson, TX 75080

**(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?**

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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:** \_\_\_\_\_

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**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**