

Serenity Health & Wellness Center

1685 Lance Point Dr. Maumee, Oh 43537
419.891.8181



**Colon Hydrotherapy Intake
Confidential Personal History Form**

Please PRINT and Answer all Questions:

Date: ___/___/20___

NAME: _____

HOME PH: _____ **ALT. PH:** _____

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

OCCUPATION: _____ **How Long?** _____

HEIGHT: _____ **WEIGHT:** _____ **BIRTH DATE:** _____ **AGE:** _____

Why have you chosen to have Colon Irrigation Session(s)? Please (√) all that apply:

- Reason: _____
- Under a Medical Provider's Care? _____ •Medical Provider Name _____
- By Prescription _____ •In Pain? _____ •Where? _____

*Contraindications: (√) and Date if you have ever had any of the following:

- DATE**
- _____ Abdominal Hernia
 - _____ Abdominal Surgery
 - _____ Abnormal Distension
 - _____ Acute Live Failure
 - _____ Anemia
 - _____ Aneurysm - all types
 - _____ Carcinoma of the Colon
 - _____ Cardiac Condition
 - _____ Crohns Disease
 - _____ Colitis
 - _____ Dialysis

- DATE**
- _____ Diverticulosis/Diverticulitis
 - _____ Fissures & Fistulas
 - _____ Hemorrhaging
 - _____ Hemorrhoidectomy
 - _____ Intestinal Perforations
 - _____ Lupus
 - _____ Pregnant - (Due Date _____)
 - _____ Rectal/Colon Surgery
 - _____ Renal Insufficiencies
 - _____ Taking medication's, which may weaken intestinal walls?

- _____ 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 (√) please 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.

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 _____

Medical Director: X _____ **Date:** ___/___/20___
Medical Director: Name Lic. # Phone

OR By Own Physician
Prescription Exp: _____

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Informed Consent

This health center _____ informs you of the following things:

1. We do not diagnose.
2. We make no attempt to cure any condition.
3. We make no claim or imply any claim that suggestions are given to cure any condition.
4. We do not claim that any supplemental material that we speak about will cure any condition or that its purpose is to treat any condition.
5. We do not prescribe or treat disease, however we do attempt to educate you on food and conscious diet choices, exercise and lifestyle choices if they are not contradictory to the recommendations of your primary health care provider or your physician.

I, the undersigned client of this health center _____, understand the above statements and understand that diet, nutrition, and lifestyle consultations are considered to be inexact sciences and that the results obtained are not always consistent or predictable.

Whether or not I participate in the procedures offered by this center is my decision based on my God-given inalienable rights and my constitutionally guaranteed rights secured by the U.S. Bill of Rights. It is Creator-endowed Inalienable Rights to ask for assistance of my own choosing and I accept full responsibility for any outcome. I understand that there is no guarantee of any result and the opposite of the desired result may appear. Whether or not I ask for assistance is my decision. All decisions relative to my health must be made by me.

I understand that all the practitioners here are not medical doctors and are not attempting to portray or conduct the activities of a medical doctor, and I waive any liability on behalf of the practitioner.

Name _____

Address _____

City _____ State _____ Zip _____

Client Signature: X _____ Date: ____/____/20____

Phone: _____ Alt. Phone: _____