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?

If any (√) please explain: _____

_____ 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 _____

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 thatis 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 thenozzle 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____ OR By Own Physician
Medical Director: Name Lic. # Phone Prescription Exp: _____

STAPLE PHYSICIAN PRESCRIPTION HERE

Medications:

_____

_____

Notes:

_____

_____

Emergency Contact: _____

Other Notes:

Session Information:

#	Date:	Therapist:	Client Initials:

Session Information:

#	Date:	Therapist:	Client Initials:

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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 conidition.

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 understant that all the practitioners here are not medical doctors and are not attempting to portray ot 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: _____