# In Carol's Care LLC Complementary Health Center *featuring Colon Hydrotherapy*

## Health History Questionnaire for Professional Colon Hydrotherapy

Please PRINT and answer all questions Date __________ / _____ /______

NAME:________________________________ Cell: ____________ Home Phone.____________

ADDRESS:____________________________ City_________________ State _____ Zip______

EMAIL:___________________________ Occupation:_________________ How Long? _______

HEIGHT: _________ WEIGHT: _________ BIRTH DATE: _____/_________/_____ AGE:_______

Are you Under a Physicians Care? _____ Name___________________________ Type:________

(ICE) In Case of Emergency contact:______________ Relation: ________ Phone: ______________

***What is a contraindication?*** *(con·tra·in·di·ca·tion)* ***A contraindication is a specific health condition in which A drug, procedure, treatment or surgery is inadvisable, as it may be harmful to the health of the patient.***

*** Contraindications: [ √ ] and Date if ever had any of the Following:**

| DATE | | DATE | |
|---|---|---|---|
| _____ | **Abdominal Hernia** | _____ | **Dialysis Patient** |
| _____ | **Abdominal Surgery** | _____ | Diverticulosis/**Diverticulitis** |
| _____ | **Abnormal Distension** | _____ | **Fissures & Fistulas** |
| _____ | **Acute Liver Failure** | _____ | **Hemorrhaging** |
| _____ | **Anemia** | _____ | **Hemorrhoidectomy** |
| _____ | **Aneurysm - All Types** | _____ | **Intestinal Perforations** |
| _____ | **Cancer-Type**____________ | _____ | **Lupus** |
| _____ | **Cardiac Condition** | _____ | **Pregnant** -(due date ______ ) |
| _____ | **Crohns Disease** | _____ | **Rectal / Colon Surgery** |
| _____ | **Colitis** | _____ | **Renal Insufficiencies** |

**Please check ( √ )**

_____ Hemorrhoids
Internal___ External____
_____ Rectal or Blood in Stool
_____ Recent Colonoscopy
_____ Use Laxatives
_____ BM Painful / Difficult
_____ Burning / Itching Anus
_____ Constipation/Diarrhea
_____ Vomiting ____ Bloating
_____ High Blood Pressure
_____ Infectious Disease
_____ Date of Last Menstrual
_____ Allergic to Latex
_____ Bladder Infection
Other____________________
or use back of form.

Please [ √ ] Date IF you have any above contraindications*.

**I have NOT been diagnosed with any contraindications for colon hydrotherapy: Client Initials X________**

**READ and INITIAL:** I am aware that this Center uses FDA Registered Medical Device(s) for Colon Hydrotherapy and only uses disposable sterile nozzles or speculums. Although all Therapist(s) on staff have Certificates showing they have completed Device Training, they may Not be required to be State Licensed or have a Degree in Health Care. This Center does have one or more area Licensed Medical Director's that 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 Home Enema Kits. Should I experience resistance during my 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 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 SIGNATURE: X**________________________________________ **Date** ___ /___ /____

*(For Clients 18 or under, the signature & attendance of the parent or guardian for insertion is required.)*

As a Trained Therapist, I will always follow the FDA Device Manufacture use & maintenance guidelines.
I have reviewed and discussed this form with above client. **Therapist Signature: X**__________________



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*Client Notes:*____________________________________________________________

__________________________________________________________________

**How did you hear about us?**

- Physician: ____________ • Friend____ • Paper____
- Family Member____ • Coupon where:____________
- Internet______________________ • Sign___________
- Other?____________________________________

**Client First Session Evaluation: Yes / No**

Did Therapist review Contraindications and inquire to any health issues? _____

Were Device, Room, Restrooms Clean? _____

Were you Covered and Comfortable? _____

Were your results Satisfactory? _____

Will you recommend to family/friends? _____

Problems or Discomfort during session? _____
Please Explain: ______________________________

How do you feel?______________________________

_____________________________________________

**Client Signature:**

**X**________________________________

**Pre Paid Sessions INITIALS**

| # | Date | Therapist | Client |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |
| 11 | | | |
| 12 | | | |

Therapist Notes of Clients needs/requests:

________________________________________

________________________________________

________________________________________

*Possible Side Effects: Increased Energy, Nausea, Vomiting, Cramping, Light Headed, 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.*



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