Easley Therapeutic Massage & Wellness Center
1000 S 5th Street Easley, SC 29640
864-306-0336
info@etmwellnesscenter.com

Colon Hydrotherapy
This procedure cleanses the large intestine of metabolic waste without the use of prescription medication or other toxic agents.

What happens during colon hydrotherapy?
The client lies on a custom treatment table in complete comfort. The client inserts a small disposable speculum into the rectum through which warm water passes into the colon. During this time, the colon hydrotherapist will gently massage the lower abdominal area to aid the dislodging of fecal matter that is adhering to the walls of the colon. There will be several fills and releases of water to clear the colon. Waste is discreetly transported into the drain line without offensive odor and without compromising the dignity of the individual.

Could you benefit from colon hydrotherapy?
If you have any of the following health problems, you may benefit from this treatment:

- Constipation or diarrhea
- Insomnia or chronic fatigue
- Headaches/Migraines
- Backaches
- Depression or irritability
- Skin problems
- Hypertension
- Difficult weight loss
- Menstrual problems
- Frequent colds
- Foul body odor
- Prostrate trouble

Owner Wendy Law is a member of the American Massage Therapy Association (AMTA) and the International Hydrocolon Therapy Association. She is a licensed massage therapist in North and South Carolina, certified in Pregnancy Massage and trained in Advanced Medical, Myofascial and Orthopedic massage. She is also a certified colonic technician. Wendy was an instructor at the Whole You School of Massage. She is trained in TMJ disorders, Carpel Tunnel and Migraine relief and Myofascial release.

Privacy Policy: We respect your privacy. You will be fully draped or covered during all treatments. If you wish, you may bring a bathing suit with you. If at any time you feel uncomfortable, please tell your therapist.
Late Policy: Please be on time. If you are late for your appointment your treatment time would have to be shortened to allow other clients to begin their treatments on time.
Cancellation: 24-hour notice is required.
Payment: Full payment is expected at time of service. We accept cash, check, MasterCard, Discover, Amex, Health Savings Plan cards, Visa, and gift certificates. Gratuity is greatly appreciated.
Gift Certificates: Nonrefundable and may be used for all therapies. Gift certificates are valid for three months unless otherwise stated.

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Colon Hydrotherapy New Client

Client Name: ____ DOB: ________________________

Phone No: ____

Email: ____ Email Notifications: Y / N

Street Address: ____

City: ____________________ State: ____________________ Zip Code: _____________________

Occupation: ____

Age: ____________________ Weight: ____________________ Height: _____________________

Referred By: ____________________________ Today's Date: ______________________________

Emergency Contact: ___________________________________ Phone: ______________________

What is your number one health goal and/or concern at this time? ________________________

____

Health History
Please check all conditions that currently or previously apply

__Accidents
__AIDS
__Addiction
__Alcoholism
__ADHD
__Anemia
__Aneurysm
__Anorexia
__Appendicitis
__Arteriosclerosis
__Arthritis
__Asthma
__Athletes Foot
__Bladder
__Blood Clots
__Broken Bone
__Bulimia
__Bursitis

__Cancer
__Chicken Pox
__Crohn's Disease
__Colitis
__Congestive Heart Failure
__Diabetes
__Diphtheria
__Eating Disorder
__Eczema
__Edema
__Emphysema
__Epilepsy
__Epstein-Barr
__Fever Blisters
__Fibromyalgia
__Fibroids
__Flu

__Goiter
__Gout
__Hernia/Rupture
__Hay Fever
__Heart Problems
__Hypertension
__Hyperglycemia
__Hepatitis
__HIV
__Irritable Bowel
__Jaundice
__Kidney Stones
__Leukemia
__Lupus
__Lymph Congestion
__Malaria
__Measles
__Mental Disorder

__Multiple Chemical Sensitivities
__Mumps
__Multiple Sclerosis
__Major Fall
__Muscular Dystrophy
__Nervous Breakdown
__Osteoporosis
__Panic Attack
__Parkinson's
__Pleurisy
__Polio
__Pneumonia
__Prostate
__Rheumatic Fever
__Rheumatism
__Scarlet Fever

__Seizures
__Shingles
__Sleeping Disorders
__Speech Dysfunctions
__Small Pox
__Spinal Injuries
__Sciatica
__Spastic Colon
__Stoke/CVA
__Surgery
__Tuberculosis
__Typhoid Fever
__Ulcers
__Unconsciousness
__Venereal Disease
__Vertigo
__Whooping Cough

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Heavy Metal Inquiry

Have you or do you take antacids? Yes__ No__
Have you or do you use aluminum pots and pans for cooking? Yes__ No__
Have you or do you work in an industrial plant with heavy metals or chemicals? Yes__ No__
Have you or do you have hobbies in which you work with heavy metals or chemicals? Yes__ No__
Have you or do you eat off of unglazed ceramic or painted dishes? Yes__ No__

Radiation Inquiry

Have you ever undergone radiation treatments? Yes__ No__
Do you watch TV regularly/use the computer for more than 4 hours per day? Yes__ No__
Do you cook food in a microwave (not reheat)? Yes__ No__
Do you or have you lived in CO, CT, FL, IL, MA, NJ, NM, NY, OH, PA, SC, UT (states with many nuclear power plants)? Yes__ No__

Indoor Air Environment

How many bowel movements do you have per day? ____
Are they normally loose ____________, holds shape ____________, hard pebbles ____________?
Does your stool sink ___________, breaks up when flushed _______?
Normally, what color is your stool: Light Brown _____ Medium Brown _____ Dark Brown _____ Black _____
Do you often have gas? Yes__ No__
Do you ever see blood in your stool? Yes__ No__
Does your stool have a foul odor? Yes__ No__
Have you had a colonic before? Yes__ No__

Digestive

Do you have trouble with:

Hemorrhoids	__Never	__Occasionally	__Frequently
Bloated Stomach	__Never	__Occasionally	__Frequently
Constipation	__Never	__Occasionally	__Frequently
Diarrhea	__Never	__Occasionally	__Frequently
Acid Reflux	__Never	__Occasionally	__Frequently

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Contraindications

A contraindication occurs when the procedure should NOT be administered or should be administered with CAUTION and/or only with a Doctor's release or prescription.

Listed are the contraindications for administering the procedure of Colon Irrigation.

1. **Abdominal Hernia –** Colonic Irrigation is contraindicated when the client has been diagnosed with an abdominal hernia or has had surgery for an abdominal hernia. The client should obtain a release from their Primary Care physician prior to administering the procedure.
2. **Abdominal Surgery –** Colonic Irrigation is contraindicated after recent abdominal surgery, since the administering of this procedure initiates peristalsis, and the use of the abdominal muscles may aggravate sutures and the healing of the incision. A minimum of 6 weeks should pass, after surgery, before Colonic irrigation should be administered. The client should obtain a release from their Primary Care Physician prior to administering the procedure.
3. **Anemia –** Colonic Irrigation is contraindicated when a client has been diagnosed with severe anemia. The client should obtain a release from their Primary Care Physician prior to administering the procedure.
4. **Aneurysm –** Colonic Irrigation is contraindicated when a doctors has diagnosed a client as having aneurysms. Procedures should be administered with extreme caution. The client should obtain a release from their Primary Care Physician prior to administering the procedure.
5. **Carcinoma –** Colonic Irrigation is contraindicated when a client has been diagnosed with Carcinoma of the colon. The client should obtain a release from their Primary Care Physician prior to administering the procedure.
6. **Cardiac Condition –** Colonic Irrigation is contraindicated when a client has had cardiac surgery or has been diagnosed with a heart condition such as uncontrolled hypertension, congestive heart failure, or other heart conditions. The client should obtain a release from their Primary Care Physician prior to administering the procedure.
7. **Dialysis Patients –** Colonic Irrigation is contraindicated when a client is restricted to fluid intake. The client should obtain a release from their Primary Care Physician prior to administering the procedure.
8. **Fissures/Fistulas** - Colonic Irrigation is contraindicated when a client has had cardiac surgery or has been diagnosed with fissures/fistulas. The client should obtain a release from their Primary Care Physician prior to administering the procedure.
9. **Hemorrhaging –** Colonic Irrigation is contraindicated when a client has a flow of bright red blood discharging from the rectum. The procedure should be administered with extreme caution. The client should obtain a release from their Primary Care Physician prior to administering the procedure.
10. **Hemorrhoidectomy –** Colonic Irrigation is contraindicated after rectal surgery. The client should obtain a release from their Primary Care Physician prior to administering the procedure.
11. **History of Digestive Problems** – Colonic Irrigation is contraindicated when the client has had a history of colon problems. The client should obtain a release from their Primary Care Physician prior to administering the procedure.
12. **Intestinal Perforations** – Colonic Irrigation is contraindicated when the client has been previously diagnosed by a Physician/Surgeon to have or has had intestinal perforations. The client should obtain a release from their Primary Care Physician prior to administering the procedure.
13. **Pregnancy –** Colonic Irrigation is contraindicated during the first and last trimester of pregnancy. Colonic Irrigation may be administered if it is considered general procedure to administer an enema prior to childbirth by the patient/client's Primary Care Giver. The Colonic Irrigation would be substituted for the enema, affording the patient/client more privacy and comfort. The client should obtain a release from their Primary Care Physician prior to administering the procedure.

14. **Renal Insufficiencies –** Colonic Irrigation is contraindicated when the client has been diagnosed to be renal insufficient. The client should obtain a release from their Primary Care Physician prior to administering the procedure.

If there is any doubt by the client or technician whether the client should receive the procedure, the client should consult their Primary Health Care Professional or Physician.

I have read the above contraindications and testify that I do not have, or have no had any of the above contraindications.

Signature: ____

Date: ____

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Informed Consent Form

Neither Easley Therapeutic nor any associated do the following things, either implied or intended:

1. We do not diagnose.
2. We make no attempt to cure any condition.
3. We make no claims or imply any claims that suggestions are given to cure any condition, or that its' purpose is to treat any condition.
4. We do not claim that any supplemental material we may 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 in/on foods and a good diet and exercise program if it is not contradictory to the recommendations of your primary health care provider or your physician.

I, ____________________________________ understand the above statements. As a client I understand that diet and nutrition is considered to be an inexact science and that the results obtained are not always constant or predictable. I also understand that there is no guarantee of any results and the opposite of the desired results may appear. Whether or not I participate in the procedure or program is my decision, based on my constitutional right of the Ninth Amendment. All decisions relative to my well-being and health must be made by me. I further understand that Easley Therapeutic Massage (or associates) are not medical doctors and are not attempting to portray themselves as medical doctors. I also understand that the medical device used in this procedure is intended for the use in Colon Irrigation, and that these devices are intended for colon cleansing when medically indicated, such as before radiological or endoscopic examinations.

If any representations have been made to me concerning this program or if I have any understanding about this program which representation and/or understandings are contrary to any of the above statements, I will indicate so on the reverse side of this form.

I, the undersigned, am in full agreement and accept the methods being utilized for the prevention or possible improving of those conditions that impair my ability to function as an individual.

Signature: ____ Date: ___________________________

Print Name: ____

Address: ____

City: __________________________ State: __________________________ Zip Code: ________________________

Phone: ____

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Colonic Signature Sheet

I certify and attest by my signature below, on each of the dates listed, that I am personally responsible for usage of any and all colon hydrotherapy equipment that I use at this facility, and that I am also personally responsible for insertion of the rectal nozzle. AT NO TIME will the staff of the facility insert the rectal nozzle for me. It is the policy of this facility that insertion of the rectal nozzle by for me. It is the policy of this facility that insertion of the rectal nozzle by a staff member is strictly prohibited. All information that the staff of Easley Therapeutic Massage gives is for educational purposes only. Please not WE ARE NOT MEDICAL DOCTORS, we do NOT diagnose, prescribe or claim to cure any ailments.

Date: ____________________________ Signature: ____

Date: ____________________________ Signature: ____

Date: ____________________________ Signature: ____

Date: ____________________________ Signature: ____

Date: ____________________________ Signature: ____

Date: ____________________________ Signature: ____

Date: ____________________________ Signature: ____

Date: ____________________________ Signature: ____

Date: ____________________________ Signature: ____

Date: ____________________________ Signature: ____

Date: ____________________________ Signature: ____

Date: ____________________________ Signature: ____

Date: ____________________________ Signature: ____