

Spring Wellness Colon Hydrotherapy Intake Form

2109 Nicollet Ave South, Suite 105, Minneapolis, MN 55404 (612)-978-8898

Origination Date: Review Date:

This form is completely confidential.
Please complete this form before your colon hydrotherapy session.

Name: _____ Date of birth: _____

Address: _____

Phone: _____

Email Address: _____

Height _____ Weight: _____ Sex: Male Female

Occupation: _____

Emergency Contact Information: _____

Relationship: _____ Phone 1: _____ Phone 2: _____

Physician: _____ Phone: _____

Are you currently under a doctor's care? Yes No (If YES, explain below)

Clinic name: _____

Date of last complete Physical Exam: _____ Results: _____

Is your Physician aware of you receiving colon hydro-therapy? Yes No

Have you ever had colon hydro-therapy? Yes No (If YES, explain where and when below)

How did you learn of our services? _____

Please state your reasons for and expectations from receiving colon hydro-therapy:

Spring Wellness Colon Hydrotherapy Intake Form

Please list all current medication (prescription or over the counter) and supplements (herbs, vitamins)

Please list known allergies (include food, drugs, environmental, chemical and etc.) and the reactions from them

Please list the type and year of all surgeries and major illnesses:

Contraindications for colon hydrotherapy

(Please check all that apply)

<input type="checkbox"/>	Anal fissure / fistula	<input type="checkbox"/>	Anemia (severe)
<input type="checkbox"/>	Aneurysm	<input type="checkbox"/>	Cardiac disease
<input type="checkbox"/>	Cirrhosis	<input type="checkbox"/>	Colonoscopy
<input type="checkbox"/>	Colon cancer /surgery	<input type="checkbox"/>	Colostomy
<input type="checkbox"/>	Crohn's disease	<input type="checkbox"/>	Diverticulosis /diverticulitis
<input type="checkbox"/>	GI hemorrhage / perforation	<input type="checkbox"/>	Hemorrhoid (severe)
<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Kidney / liver disease
<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	Rectal bleeding
<input type="checkbox"/>	Surgeries (recent)	<input type="checkbox"/>	Tumor in rectum /intestines
<input type="checkbox"/>	Ulcerative colitis	<input type="checkbox"/>	Subject to frequent seizures
<input type="checkbox"/>		<input type="checkbox"/>	

Please sign below confirming that you do not have any of the above contraindications.

Client signature: _____

Spring Wellness Colon Hydrotherapy Intake Form

Yes No

- Do you suffer from constipation?
- Do you suffer from diarrhea?
- Do you suffer from alternating periods of constipation and diarrhea?
- Do you suffer from hemorrhoids? (circle all that apply)
Internal/ External / Both – Mild / Moderate / Severe
- Have you ever had hemorrhoids surgically corrected? When? _____
- Do you take laxatives? What type? _____ How often? _____
- Do you take diuretics? What type? _____ How often? _____
- Do you take fiber? What type? _____ How often? _____
- Do you take stool softeners? What type? _____ How often? _____

How often do you have a bowel movement? _____

Daily habits	Heavy	Moderate	Light
Alcohol			
Coffee			
Tobacco			
Drugs			
Exercise			
Appetite			
Sleep			
Stress			

Colon hydro-therapy is a process, not a quick cure. Multiple sessions combined with good eating habits and regular exercise is necessary to achieve optimum results.

Spring Wellness
Colon Hydrotherapy Intake Form

Spring Wellness
Client Consent Form

I had reviewed Spring Wellness's intake form. I declared the information I have disclosed herein to be true and accurate. I agree and understand the information presented to me.

I am aware that the colon hydro therapist is not a physician and therefore does not diagnose or prescribe. This facility does not claim to cure or treat any condition or disease. I am aware adverse events such as perforation, injury and illness have been alleged and claim with the use of colon irrigation and enema devices. If during the session, I experience discomfort or pain, I am responsible for immediately stopping my session. For receiving colon hydrotherapy instructions and sessions at Spring Wellness, I release and forever discharge therapist and all other associated of Spring Wellness from any and all responsibility or liability arising from these procedures and demonstrations.

I realize and acknowledge that the instructions, recommendations and services given are not medical treatment or prescriptions. Any changes or additions in my diet, exercise, or supplementation are of my own choosing. I have been instructed and understand to consult my physician before entering into any lifestyle changes. This form has been fully explained to me and I certify I understand its contents.

Cancellation Policy: As a courtesy to other clients and therapists, appointments must be cancelled 24 hours in advance. You are charged in full for all scheduled appointments. No-shows will be charged in full.

What if I arrive late? Arriving to your appointment late will simply limit the time for your session. Your session will end on time so that the next client will not be delayed. If you arrive late it is up to you whether you prefer to receive a shortened session or pay for the appointment and reschedule.

(Print Name)

(Signature)

(Date)