

Place Business Name address phone across the top of form

Health History Questionnaire for Colon Hydrotherapy

Please PRINT and Answer all Questions:

Date: ____/____/____

NAME: _____ (cell ph) _____ (work ph) _____

ADDRESS: _____ City _____ State _____ Zip _____

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 _____

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

or use back of form.

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 Colon Hydrotherapy Device(s) and the Trained Therapist is not required to be State Licensed. This Center does have a Licensed Medical Director 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 Enema kits. Should I experience resistance during my 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.

As a Trained Therapist, I do NOT insert, diagnose, prescribe and do not cure or treat any condition or disease.

I have read and understand my responsibilities for colon hydrotherapy sessions: Client Initials X _____

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 LIBBE Manufacture operation & maintenance guidelines.

I have reviewed and discussed this form with above client. **Therapist Signature: X _____**

Notes: _____

How did you hear about us?

- Physician: _____ • Friend _____ • Paper _____
- Family Member _____ • Coupon where: _____
- Internet _____ • Colonic.Net _____ • Sign _____
- Other? _____

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:

Flex cut ___ normal or needs ___ Inches

Likes _____ session room.

Tummy Warmer ___ Yes ___ No

Other:- _____

PREPAID DISCOUNTED COLONIC SESSION PACKAGES SOLD AS FOLLOWS:

1. All Prepaid Discounted Colonic Sessions are to be used within six (6) months of purchase.
2. No Show appointments are counted as a used session without a 12 hour advance cancellation.
3. Health History should be updated after twelve sessions. No Refunds! Non-Transferable!

CLIENT SIGNATURE: X _____ Date ___/___/___

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 maintainance to prevent bacteria growth and/or operated by untrained therapists.

Tiller MIND BODY, Inc., San Antonio, Texas Manufacturer and Distributor of "The LIBBE" www.colonic.net
Worldwide since 1995 by Healthcare Professionals is in conformance with USA.- FDA,) ISO 13485:2003, Licensed Medical Device Manufacturer; Health Canada, Mexico, Australia, (CE) European Union, Hong Kong, (China Pending)

Health History Questionnaire (2. of 2. Pages)

