



## COLON HYDROTHERAPY INFORMED CONSENT

I, \_\_\_\_\_, have decided to undergo a Colon Hydrotherapy procedure.

Colon Hydrotherapy is intended to irrigate the lower bowel. The colon is filled and emptied with filtered water either warm or cold. I understand that there may be benefits resulting from this procedure, however, I understand and agree that no warranties have been made as to the effectiveness or outcome of this procedure.

I understand that I will insert a tube/speculum into my rectum, and agree that I will witness that the tubing is sterile from a new container; the technician using sterile or new instruments.

Possible side effects of Colon Hydrotherapy include but are not limited to:

1. Perforation of the rectum or colon; the risk of which increases with age. I agree that I am not over the age of 65 or under the age of 18. \_\_\_\_\_ Initial
2. Allergic reaction to nozzle or solution \_\_\_\_\_ Initial
3. Electrolyte imbalance \_\_\_\_\_ Initial
4. Infection. \_\_\_\_\_ Initial

I confirm that I do not have the following contraindicated conditions which would make me ineligible for Colon hydrotherapy: Kidney Dialysis/Disease, Renal failure or renal insufficiency (kidney failure), Cirrhosis of the Liver, Pregnancy. \_\_\_\_\_ Initial

I understand that Colon hydrotherapy should be avoided by people suffering from the following, unless prescribed by a physician: Anemia (severe), Aneurysm, Carcinoma, Cardiac Disease (severe, uncontrolled hypertension/high blood pressure), Crohn's Disease, Congestive heart failure, Diverticulitis (severe or acute), Fissures/fistulas, GI Hemorrhage/Perforation, Hemorrhoids (excessive bleeding present), Hernia (Incarcerated Abdominal), Prostatitis, Recent Abdominal Surgery (last six months), Tumors, Ulcerative Colitis. I confirm that I am not suffering from any of these ailments. \_\_\_\_\_ Initial. If I do have any of these ailments, I have a doctor's prescription to receive treatment today. \_\_\_\_\_ Initial.

I confirm that I am not a woman who is pregnant as this would make me an unsuitable candidate for this procedure. \_\_\_\_\_ Initial

This list is not meant to be inclusive of all possible risks associated with colon hydrotherapy as there are both known and unknown side effects associated with any medication or procedure.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent for this colon hydrotherapy treatment and release the doctor, the person performing the colon hydrotherapy procedure and the facility from liability associated with this and all subsequent treatments with the above understood.

Client Signature \_\_\_\_\_ Date: \_\_\_\_\_



## CLIENT INFORMATION & MEDICAL HISTORY COLON HYDROTHERAPY

### PERSONAL HISTORY

Client Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone(\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ Mobile (\_\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_ Marital Status \_\_\_\_\_

Emergency Contact Name and Phone \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

### MEDICAL HISTORY

Are you currently under the care of a physician?  Yes  No If yes, for what? \_\_\_\_\_

Do you have a prescription for this visit? \_\_\_\_\_ If yes, do we have a copy on file? \_\_\_\_\_ If yes, Date \_\_\_\_\_

Is Colon Hydrotherapy part of a protocol that a healthcare professional has referred or prescribed for you?  Yes  No

If yes, Doctors and Type of Doctor \_\_\_\_\_

Reason \_\_\_\_\_ Date of referral/prescription \_\_\_\_\_

Do you have any of the following medical conditions? Please check all that apply:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> <b>Abdominal Hernia</b>        | <input type="checkbox"/> <b>Abdominal Surgery</b>  | <input type="checkbox"/> <b>Abnormal Distension</b> | <input type="checkbox"/> <b>Acute Liver Failure</b>     |
| <input type="checkbox"/> <b>Anemia</b>                  | <input type="checkbox"/> <b>Aneurysm-All Types</b> | <input type="checkbox"/> <b>Cancer of the Colon</b> | <input type="checkbox"/> <b>Cardiac Condition</b>       |
| <input type="checkbox"/> <b>Crohns Disease</b>          | <input type="checkbox"/> <b>Colitis</b>            | <input type="checkbox"/> Dialysis Patient           | <input type="checkbox"/> <b>Diverticulitis</b>          |
| <input type="checkbox"/> <b>Fissures &amp; Fistulas</b> | <input type="checkbox"/> <b>Hemorrhaging</b>       | <input type="checkbox"/> <b>Hemorrhoidectomy</b>    | <input type="checkbox"/> <b>Intestinal Perforations</b> |
| <input type="checkbox"/> <b>Lupus</b>                   | <input type="checkbox"/> <b>Pregnant</b>           | <input type="checkbox"/> Rectal/Colon Surgery       | <input type="checkbox"/> Renal Insufficiencies          |
| <input type="checkbox"/> Irritable Bowel Syndrome       | <input type="checkbox"/> AIDS                      | <input type="checkbox"/> Diverticulosis             | <input type="checkbox"/> Bladder Infections             |
| <input type="checkbox"/> Bloating                       | <input type="checkbox"/> Blood in Stool            | <input type="checkbox"/> Itching Anus               | <input type="checkbox"/> Constipation                   |
| <input type="checkbox"/> Diarrhea                       | <input type="checkbox"/> Colonoscopy               | <input type="checkbox"/> Rectal Bleeding            | <input type="checkbox"/> Infectious Disease             |
| <input type="checkbox"/> Heaptitis B or C               | <input type="checkbox"/> Hemorrhoids               | <input type="checkbox"/> Parasites                  |   |

Do you have any communicable Disease?  Yes  No If yes, explain: \_\_\_\_\_

Do you have any other health problems or medical conditions: Pleaselist: \_\_\_\_\_

\_\_\_\_\_



**MEDICATIONS & SUPPLEMENTS**

List all you now take regularly including over the counter: \_\_\_\_\_  
\_\_\_\_\_

Do you take digestive aids/laxatives?  Yes  No If yes, describe: \_\_\_\_\_

Are you on any steroids?  Yes  No Injections/oral \_\_\_\_\_

Are you on any blood thinners?  Yes  No Are you on any diuretics?  Yes  No

What was the most recent time you took antibiotics? \_\_\_\_\_ Why? \_\_\_\_\_

**ADDITIONAL INFORMATION:**

Describe your regular routine for exercise: \_\_\_\_\_  
\_\_\_\_\_

On a scale of 1 to 10 where 1 = can't get out of bed and 10=optimal energy, describe your normal energy level: \_\_\_\_\_

How many servings of vegetables do you eat per day? \_\_\_\_\_ How many servings of fruit per day? \_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_

How much dairy do you eat per day? \_\_\_\_\_ How much meat do you eat per day or week? \_\_\_\_\_

Do you smoke?  Yes  No If yes, how much and how long? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, how much and how long? \_\_\_\_\_

How often do you have a bowel movement? \_\_\_\_\_ skips days \_\_\_\_\_ 1 per day \_\_\_\_\_ 2 per day \_\_\_\_\_ 3 per day

Color and consistency of bowel movement \_\_\_\_\_

What do you hope to achieve from this colon hydrotherapy appointment? \_\_\_\_\_  
\_\_\_\_\_



Do you have specific concerns?  Yes  No If yes, explain: \_\_\_\_\_

My signature below indicates that I have honestly answered all of the questions above and supplied any additional relevant information within this intake form.

\_\_\_\_\_  
Client Name (Printed clearly)

Date: \_\_\_\_\_

\_\_\_\_\_  
Client Signature



## POLICIES

### Appointment Policies

In our efforts to provide quality and timely service to all clients, the following appointment and center policies are in effect:

- A 24-hour notification of cancellation is required for all services. A \$35.00 cancellation fee is applied if not cancelled within the 24-hour window.
- No show appointments are counted as a used session without a 12-hour advance cancellation notice.
- Colon hydrotherapy sessions are non-transferable and are good up to one year after purchase.
- If you purchase a series of colonics, sessions may not be divided amongst individuals, exchanged for product or transferred to another person.
- All product sales are final.

We value your time and strive for a zero wait for scheduled services. To that end, out of courtesy for the next scheduled client and the practitioner, session times will be reduced in the event a client is more than 15 minutes late.

### Payment Policies

Payments may be made with cash, check or credit/debit card and are to be received at the time of the scheduled appointment unless you are paying for future sessions in order to receive deeper discounts.

If any check, debit, or credit card charge payable to QC Colon Hydrotherapy is returned, rejected or dishonored, management will, in each instance (a) assess a charge equal to any charge imposed by the financial institution, any costs and expenses incurred in connection with collection plus an administrative fee of twenty-five dollars (\$25), and (b) collect the current and past due balance in any subsequent month.

By signing I confirm these policies have been fully explained to me, and I certify I understand their contents.

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Client Signature

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Date