Colon Hydrotherapy

All Questions Must Be Answered

Please Print Name_____ Date _____

Are you allergic to **Coconut Oil?** **Yes** ☐ **or No** ☐

WHAT ARE YOU EXPECTING TO RECEIVE FROM THIS APPOINTMENT?

Is there anything specific you would like to work on during the session? What are your long-range goals?

Today: _____

Long-Range: _____

You MUST check (yes or no) for all of the following CONTRAINDICATIONS.

	Yes	No		Yes	No		Yes	No
1st Trimester of Pregnancy			**Chemo/radiation treatment**			**Renal Insufficiency**		
Abdominal Hernia			**Cirrhosis**			**Severe Anemia**		
Advanced Pregnancy			**Colon Surgeries**			**Severe Cardiac Disease**		
AIDS/HIV			**Crohn's Disease**			**Severe Diverticulitis**		
Aneurysm			**Fissures/Fistulas**			**Severe Hemorrhoids**		
Cancer			**GI Hemorrhage/Perforation**			**Ulcerated Colitis**		

If yes please explain and give date of diagnosis: _____

Is the contraindication currently active? Yes ☐ or No ☐

For the following please write #1 , #2, #3, OR if it does not apply please check NO

1. If symptom is occasional/mild 2. If symptom is frequent/moderate 3. If symptom is severe/constant

Understand this section is optional but it helps the therapist to prepare a better session for you.

If you choose not to answer *Please initial.* _____

HEALTH HISTORY	NO	#	HEALTH HISTORY	NO	#	HEALTH HISTORY	NO	#
Allergies			**Digestive Problems**			**Menstrual problems**		
Allergies drug reaction			**Diverticulosis**			**Muscle / Joint pain**		
Anemia			**Dizziness**			**Muscle Stiffness**		
Anorexia/ Bulimia			**Double/blurred vision**			**Neuropathy**		
Arthritis			**Earache**			**Organ Transplant**		
Asthma			**Edema/ swelling**			**Pacemaker**		
Back problems/pain			**Excess Gas**			**Poor appetite**		
Bad breath			**Excessive hair loss**			**Prostate problem**		
Bitter metallic taste			**Fatigue**			**Seizures**		
Bladder disorders			**Frequent colds**			**Sinus Problems**		
Bladder infection			**Headaches**			**Skin disease**		
Bronchitis			**Heart-burn/ acid reflux**			**Uterus disorder**		
Burping			**HEP-C / HIV / Aids**			**Uterus/ Ovary problems**		
Chronic cough			**Hemorrhoids**			***Other conditions**		
Chronic fatigue			**High/low blood pressure**			**Please List below.**		
Colitis			**Insomnia**					
Cold Sores			**Irritable bowel (IBS)**					
Constipation			**Liver disorders**					
Depression			**Lung disorders**					
Diabetes			**Lupus**					

If you answered yes to any please explain and indicate how long you have had this situation: _____

_____

Colon Hydrotherapy (Continued)

I have been informed and agree to self-insertion and self-retraction of the speculum. ***Please initial*** _____

Have you ever had a colonic before? _____ If yes, when was your last session: _____

How many bowel movements per day do you have? _____Do you strain to have a bowel movement? _____

Do you use a stool softener or laxative? _____Herbal laxative?_____ Suppository?_____

Do you have hemorrhoids or other rectal problems? _____

Have you ever had bleeding from colitis or any bodily orifice? _____

If yes, please explain_____

Have you ever had a barium enema? _____ If so when? _____

Have you ever had a colonoscopy? _____ If so when? _____

Providing the following information is optional but helpful.

Yes	No		If Yes Please Explain
		Do you drink alcohol?	
		Do you drink coffee?	
		Do you smoke?	
		Have you ever used drugs recreationally?	
		Are you currently taking prescription drugs?	
		Do you have irregular sleeping habits/insomnia?	
		Do you have any reaction if meals are delayed?	
		Do you have indigestion?	

Please state what you normally eat at the following meals:

Breakfast	Lunch	Dinner

How much water do you drink per day? _____

Are you always hungry/never hungry or eat when nervous? _____

Do you have reactions when meals are delayed? _____

Do you crave any foods? *If YES give details:* _____

Please read carefully before signing

"The purpose of Gentle Wellness Center and all our staff is to provide services and offer information to clients. Our services and information are for the purpose of vocational and advocational self-improvement. All procedures are directed towards the establishment of this goal."

I have honestly answered all above questions and am not intentionally withholding information about my health. I am agreeing to office policies and procedures of Gentle Wellness Center.

Signature: _____ **Date:** _____